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HEALTH SECURITY ACT

AUGUST 2, 1994.—Ordered to be printed

Mr. MONTGOMERY, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany H.R. 3600 which on November 20, 1993, was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI and part 1 of subtitle C of title V as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time if the Speaker so designates), to the Committee on Armed Services for consideration of subtitle A of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(c) of rule X, to the Committee on Veterans' Affairs for consideration of subtitle B of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(u) of rule X, to the Committee on Post Office and Civil Service for consideration of subtitle C of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(o) of rule X, to the Committee on Natural Resources for consideration of subtitle D of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(n) of rule X, to the Committee on the Judiciary for consideration of subtitles C through F of title V and such other provisions as fall within its jurisdiction pursuant to clause 1(l) of rule X, to the Committee on Rules for consideration of sections 1432(d), 6006(f), and 9102(e)(5), and to the Committee on Government Operations for consideration of subtitle B of title V and section 5401]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 3600) to ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans, having considered the same, reports favorably thereon with an amendment, by

ensure and protect the health care of all Americans, having considered the same, reports favorably thereon with an amendment, by unanimous voice vote, and recommends that the bill as amended do pass.

The amendment is as follows:

Strike subtitle B of title VIII (page 1218, line 1, through page 1233, line 4) and insert the following:

Subtitle B—Department of Veterans Affairs

SEC. 8101. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

"CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER ENROLLMENT-BASED SYSTEM

"SUBCHAPTER I—GENERAL

"§ 1801. Definitions

"For purposes of this chapter:

"(1) The term 'health plan' means an entity that has been certified under the Health Security Act as a health plan.

"(2) The term 'VA health plan' means a health plan that is operated by the Secretary under section 7341 of this title.

"(3) The term 'VA enrollee' means an individual enrolled under the Health Security Act and subchapter II of this chapter in a VA health plan.

"(4) The term 'comprehensive benefit package' means the package of benefits required to be provided by a health plan under the Health Security Act.

"SUBCHAPTER II—ENROLLMENT

"§ 1811. Enrollment: veterans

"Each veteran who is an eligible individual within the meaning of section 1001 of the Health Security Act (including a veteran who is a medicare-eligible individual as defined in section 1902 of that Act) may enroll with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the Department shall enroll with a VA health plan.

"§ 1812. Enrollment: CHAMPVA eligibles

"(a) ELIGIBILITY.—An individual described in subsection (b) who is eligible to enroll in a health plan pursuant to section 1001 of the Health Security Act may enroll under that Act with a VA health plan.

"(b) APPLICABILITY.—This section applies to the following individuals who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS):

"(1) The surviving spouse or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

"(2) The surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct.

"(c) DEFINITION OF CHILD.—For purposes of this section, the term 'child' has the meaning given that term in section 1011 of the Health Security Act.

"§ 1813. Enrollment: family members

"(a) ELIGIBILITY.—The Secretary shall authorize a VA health plan to enroll members of the family of an enrollee under section 1811 or 1812 of this title. The enrollee shall have the option of enrolling in the VA health plan as an individual or with family members. If the enrollee chooses to enroll in the VA health plan with family members, all such family members must be so enrolled.

"(b) REQUIRED PAYMENTS.—Any family member enrolled in a VA health plan shall (except as provided in section 1831(c)(2)(B) of this title) be subject to payment of premiums, deductibles, copayments, and coinsurance as required under the Health Security Act.

"(c) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH OF VETERAN.—An individual who is enrolled with a VA health

plan pursuant to subsection (a) as a member of the family of a veteran enrolled under section 1811 of this title shall not lose eligibility to be enrolled with VA health plans by reason of the death of that veteran.

"(d) MEMBERS OF FAMILY.—For purposes of this section, the members of the family of an enrollee are those individuals (other than the enrollee) included within the term 'family' as defined in section 1011(b) of the Health Security Act.

"SUBCHAPTER III—BENEFITS

"§ 1821. Benefits for VA enrollees

"The Secretary shall ensure that each VA health plan provides to each individual enrolled with it the items and services in the comprehensive benefit package under the Health Security Act.

"§ 1822. Chapter 17 benefits

"(a) CARE AND SERVICES NOT INCLUDED IN COMPREHENSIVE BENEFIT PACKAGE.—In the case of care and services that may be provided under chapter 17 of this title that are not included in the comprehensive benefit package, the Secretary shall provide to any veteran (whether or not enrolled with a health plan) the care and services authorized under that chapter in accordance with the terms and conditions applicable to that veteran and that care under that chapter.

"(b) VETERANS WHO ARE NOT ELIGIBLE TO ENROLL UNDER HEALTH SECURITY ACT.—In the case of a veteran who is not an eligible individual within the meaning of section 1001 of the Health Security Act, the Secretary shall provide to the veteran the care and services that may be provided under chapter 17 of this title through any facility of the department, whether or not the facility is operating as or within a VA health plan.

"(c) PRESERVATION OF SPECIALIZED DVA TREATMENT CAPACITIES.—In carrying out subsection (a), the Secretary shall ensure that the Department maintains the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services for those specialized needs. The Secretary shall ensure that overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this chapter. Nothing in this subsection precludes the Secretary from expanding the number or type of facilities or programs that provide treatment and rehabilitation services

for the specialized needs of such veterans, including provision of specialized services on an outpatient basis.

"(d) ANNUAL REPORT.—Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the actions the Secretary has taken to carry out subsection (c) during the preceding fiscal year. Each such report shall include a statement of the number of veterans to whom the Department provided specialized services that are covered by the report and the expense of providing those services, and a description of the alternatives available in the private sector for the provision of those services to veterans.

"§ 1823. Supplemental benefits packages and policies

"A VA health plan may offer supplemental health benefits packages and supplemental cost sharing policies consistent with the requirements of part 2 of subtitle E of title I of the Health Security Act. However, a VA health plan may not offer a supplemental health benefits package to a veteran that provides coverage for services that the Department is required to provide to that veteran under chapter 17 of this title.

"§ 1824. Limitation regarding veterans enrolled with health plans outside Department

"(a) REIMBURSEMENT REQUIRED.—A veteran who is residing in an area in which the Department operates a health plan and who is enrolled in a health plan that is not operated by the Department may be provided the items and services in the comprehensive benefit package by a VA health plan operating in that area only if (except as provided in subsection (b)) the plan is reimbursed in accordance with the Health Security Act for the cost of the care provided.

(b) EXCEPTION.—The Secretary may not impose on or collect from a veteran described in subsection (a) a cost-share charge of any kind in the case of treatment for a service-connected disability that (as determined by the Secretary) requires a specialized treatment capacity for which the Department has particular expertise.

"§ 1825. Abortions through VA health plans: prohibition

"(a) PROHIBITION.—Notwithstanding the provisions of the comprehensive benefit package, a VA health plan may not provide abortions (either by the performance of an abortion in a Department facility or by payment for the performance of an abortion outside a Department facility), except in a case in which—

"(1) a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death if the fetus were carried to term; or

"(2) the pregnancy is the result of a forcible rape or incest.

"(b) CONSTRUCTION OF ABORTION EXCLUSION.—Subsection (a) shall not be construed to remove or diminish coverage of any reproductive health service, family planning service, or service for pregnant women otherwise provided for under this title, except abortions.

"(c) NO AUTHORITY TO ALTER ABORTION EXCLUSION.—Notwithstanding any provision of the Health Security Act, the National Health Board may not expand the comprehensive benefit package to include any abortion that is excluded under subsection (a).

"SUBCHAPTER IV—FINANCIAL MATTERS

"§ 1831. Premiums, copayments, etc.

"(a) EXEMPTION OF CERTAIN VETERANS.—In the case of a veteran described in subsection (b) who is a VA enrollee, there may not be imposed or collected from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items and services in the comprehensive benefit package that are provided to the veteran by the Secretary within a VA plan provider network. The Secretary shall make such arrangements as necessary with the appropriate health insurance purchasing cooperative or with appropriate Federal, State, or other officials in order to carry out this subsection.

"(b) VETERANS EXEMPT FROM CHARGES.—The veterans referred to in subsection (a) are the following:

"(1) Any veteran with a service-connected disability.

"(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

"(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

"(4) Any veteran who is a former prisoner of war.

"(5) Any veteran of the Mexican border period or World War I.

"(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

"(c) OTHER ENROLLEES.—(1) In the case of a VA enrollee who is not described in subsection (b), the Secretary shall (except as provided in paragraph (2)) charge premiums and shall establish copayments, deductibles, and coinsurance amounts.

"(2) The Secretary may not collect from an enrollee a premium in the case of—

"(A) an individual who is enrolled in a VA health plan by reason of eligibility under section 1812 of this title; or

"(B) an individual who is enrolled in a VA health plan by reason of eligibility under section 1813 of this title and who is described in paragraph (1) of section 1713(a) of this title.

"(3) The Secretary may not charge a copayment, deductible, or other coinsurance amount in the case of care for any disease covered under section 1710(e)(1) of this title.

"(d) ESTABLISHMENT OF RATES.—The premium rate, and the rates for deductibles and copayments, for each VA health plan shall be established by that health plan based on rules applicable to all health plans operating in the geographic area in which it is operating.

"(e) SELF-EMPLOYED SERVICE-CONNECTED VETERANS.—In the case of a veteran with a service-connected disability who is enrolled in a VA health plan and who has net earnings from self-employment, the Secretary shall, under regulations prescribed by the Secretary, provide for the waiver of any premium payment (or alliance credit repayment) owed by the veteran under section 6126 or 6111 of the Health Security Act by virtue of the veteran's net earnings from self-employment.

"(f) DUTIES OF EMPLOYERS.—The obligations (including obligations with respect to payment of premiums) under the Health Security Act of an employer with respect to employees who are enrolled in a VA health plan, and with respect to such a plan, shall be the same as those that apply with respect to other employees and other health plans.

"§ 1832. Medicare coverage and reimbursement

"(a) PAYMENTS FROM HHS.—In the case of care provided by the Department to an individual who is a Medicare-eligible individual other than a veteran described in section 1831(b) of this title, the Secretary of Health and Human Services shall reimburse the Department health-care facility or VA health plan that (under subsection (b)) provides that care as a Medicare provider or Medicare HMO in the same amounts and in the same manner as that Secretary reimburses other Medicare providers or Medicare HMOs, respectively. The Secretary of Health and Human Services shall include with each such reimbursement a Medicare explanation of benefits.

"(b) MEDICARE STATUS.—(1) For purposes of the Medicare program—

"(A) a Department health care facility providing care to a Medicare-eligible individual for which there is a certification in effect under paragraph (2) shall be deemed to be a Medicare provider; and

"(B) a VA health plan providing care to a Medicare-eligible individual for which there is a certification in effect under paragraph (2) shall be deemed to be a Medicare HMO.

"(2) The Secretary shall certify to the Secretary of Health and Human Services each year—

"(A) a list of all Department health care facilities that, with respect to Medicare requirements that are applicable to a public facility, either fully meet or exceed Medicare requirements, or fully comply with requirements of the Secretary that are intended to achieve the same or similar purposes as Medicare requirements and which are no less stringent than such Medicare requirements; and

"(B) a list of all VA health plans that, with respect to Medicare HMO requirements that are applicable to a health plan of a public entity, either fully meet or exceed Medicare HMO requirements, or fully comply with requirements of the Secretary that are intended to achieve the same or similar purposes as Medicare HMO requirements and which are no less stringent than such Medicare requirements.

"(c) DEDUCTIBLES AND COPAYMENTS.—When the Secretary provides care to an enrollee with a VA health plan for which the Secretary receives reimbursement under this section, the Secretary shall require the enrollee to pay to the Department any applicable deductible or copayment that is not covered by the Medicare program.

"(d) DEFINITIONS.—For purposes of this section:

"(1) The term 'Medicare program' means the health insurance program under title XVIII of the Social Security Act.

"(2) The term 'Medicare-eligible individual' means an individual who is entitled to benefits under part A of the Medicare program.

"(3) The term 'Medicare HMO' means an eligible organization under section 1876 of the Social Security Act.

"(4) The term 'Medicare provider' means an individual or entity furnishing items or services for which payments may be made under the Medicare program.

"§ 1833. Recovery of cost of certain care and services

"(a) RECOVERY FROM THIRD PARTIES.—In the case of an individual provided care or services through a VA health plan who has coverage under a supplemental health insurance policy pursuant to part 2 of subtitle E of title I of the Health Security Act or under any other provision of law, or who has coverage under a Medicare supplemental health insurance plan (as defined in the Health Security Act) or under any other provision of law, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such

party if the care or services had not been furnished by a department or agency of the United States.

"(b) PROCEDURES.—The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"§ 1834. Health Plan Fund

"(a) ESTABLISHMENT OF FUND.—There is hereby established in the Treasury a revolving fund to be known as the 'Department of Veterans Affairs Health Plan Fund'.

"(b) CREDITING OF AMOUNTS TO FUND.—There shall be credited to the revolving fund any amount received by the Department by reason of the furnishing of health care by a VA health plan and any amount received by the Department by reason of the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles), any amount received as a third-party reimbursement, and any amount received as a reimbursement from another health plan for care furnished to one of its enrollees.

"(c) CREDITING TO TREASURY.—Any amounts deposited to the revolving fund that are attributable to amounts received by the Department as a premium by reason of the enrollment with a VA health plan of a veteran described in section 1831(b) of this title shall be covered into the General Fund of the Treasury.

"(d) AVAILABILITY OF FUNDS.—Amounts in the revolving fund are hereby made available for all expenses, both direct and indirect, related to the delivery by a VA health plan of the items and services in the comprehensive benefit package and any supplemental benefits package or policy offered by that health plan.

"§ 1835. Guaranteed funding of Government costs

"(a) REQUIRED DEPOSITS FROM TREASURY.—The Secretary of the Treasury shall deposit into the Department of Veterans Affairs Health Plan Fund on the first day of each fiscal year quarter, from amounts not otherwise appropriated, the amount certified to the Secretary under subsection (b) with respect to the fiscal year quarter beginning on that date. The first such deposit shall be made with respect to the first fiscal year quarter during which the Secretary operates a VA health plan under the Health Security Act.

"(b) CERTIFICATION OF AMOUNT.—Not later than 30 days before the beginning of each fiscal year quarter, the Secretary of Veterans Affairs shall certify to the Secretary of the Treasury the amount determined for that quarter under subsection (c).

"(c) DETERMINATION OF AMOUNT.—(1) The amount to be certified to the Secretary of the Treasury under subsection (b) for any fiscal year quarter is the product of—

"(A) the projected number of VA enrollees described in section 1831(b) of this title as of the beginning of that fiscal year quarter, and

"(B) the capitated enrollment amount for that fiscal year determined under subsection (d).

"(2) The Secretary shall adjust future certifications under this subsection to take account of—

"(A) differences between the actual number of veterans described in section 1831(b) of this title enrolled for a fiscal year quarter and the projected number used in the certification for that quarter pursuant to paragraph (1); and

"(B) any information that the Secretary finds would produce a more accurate capitated enrollment amount by enabling the Secretary to estimate more accurately the costs that the Department will incur during the period covered by any such certification in providing those services that are specified to be included in the comprehensive benefit package.

"(d) CAPITATED ENROLLMENT AMOUNT.—(1) The Secretary shall determine the capitated enrollment amount for purposes of subsection (c). The initial capitated enrollment amount shall be determined as the amount equal to—

"(A) the annual full cost (as defined in OMB Circular A–25, issued on July 8, 1993) that has been incurred by the Department in providing those services that are specified to be included in the comprehensive benefit package, based upon the most recent cost data available as of the time of the determination, adjusted for inflation to the date of the determination based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, divided by

"(B) the total number of veterans described in section 1831(b) of this title who received those services.

"(2) The Secretary shall include in the total annual cost for purposes of paragraph (1)(A) the amount appropriated for fiscal year 1994 for the medical and prosthetic research functions of the Veterans Health Administration.

"(3) The Secretary shall develop the methodology for determining the initial capitated enrollment amount under paragraph (1) in consultation with the Comptroller General of the United States. If the Comptroller General disagrees with the methodology proposed to be used by the Secretary, the Comptroller General shall promptly notify the Committees on Veterans' Affairs of the Senate and House of Representatives. The determination of that amount shall be made not later than June 1, 1995.

"(4) The initial capitated enrollment amount, as adjusted annually for inflation based upon the medical care consumer price index calculated by the Bureau of Labor

Statistics, shall apply for the first five fiscal years during which the Secretary operates a VA health plan.

"(5)(A) Not later than the end of the third fiscal year during which the Secretary operates a VA health plan, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on what actions, if any, would be necessary in order for the Department to change the annual capitated enrollment amount by the end of the fifth such year from the initial amount determined under paragraph (1) to an amount determined using the method described in subparagraph (B), or to amounts determined using some other methodology, without a reduction in quality of care.

"(B) The method for determining the annual capitated enrollment amount for purposes of the study under this paragraph is to determine the average premium that would be payable under the Health Security Act for individuals enrolled in health plans other than VA health plans which have enrollment populations with disproportionate numbers of persons with similar demographic and patient-risk characteristics to the population of VA enrollees.".

(2) CLERICAL AMENDMENT.—The tables of chapters at the beginning of title 38, United States Code, and at the beginning of part II of such title, are amended by inserting after the item relating to chapter 17 the following new item:

"18. Eligibility and Benefits Under Enrollment-Based System ..... 1801".

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OPERATING AS HEALTH PLANS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

"§ 1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans

"The provisions of this chapter shall apply with respect to the furnishing of care and services—

"(1) by any facility of the Department that (A) is not operating as or within a health plan certified as a health plan under the Health Security Act, and (B) is not located in a State (or portion of a State) that under the Health Security Act is a single payer area; and

"(2) by any facility of the Department (whether or not operating as or within a health plan certified as a health plan under the Health Security Act) in the case of a veteran who is not an eligible individual with the meaning of section 1001 of the Health Security Act.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

"1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans.".

SEC. 8102. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS HEALTH PLANS.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"§ 7341. Organization of health care facilities as health plans

"(a) Except as provided in section 7342 of this title, the Secretary shall organize health plans and operate Department facilities as or within health plans under the Health Security Act. The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as or within health plans under that Act. In prescribing those standards, the Secretary shall assure that they conform, to the maximum extent practicable, to the requirements for health plans generally set forth in part 1 of subtitle E of title I of the Health Security Act.

"(b) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single health plan encompassing all Department facilities within that area or region or may be organized to operate as several health plans.

"(c) Within a geographic area or region other than a State (or portion of a State) that under the Health Security Act is a single payer area, any health insurance purchasing cooperative, health alliance, or similar entity that offer health insurance plans shall offer as an option to eligible individuals any VA health plan that is operating in that area or region.

"(d) Any health insurance program that is provided for Federal employees shall include VA health plans as enrollment options for eligible individuals. Premiums shall be paid to a VA health plan under any such insurance program based upon enrollment with that plan in the same manner as to any other health plan.

"(e)(1) In establishing and operating health plans, the Secretary, in consultation with the Comptroller General, shall take appropriate steps to ensure the financial solvency and stability of each VA health plan and of contractors and subcontractors providing services pursuant to section 7343 of this title.

"(2) In carrying out paragraph (1), the Secretary may purchase from commercial sources insurance to insure the Department against the financial risks involved in the operation of any VA health plan.

"(3) Notwithstanding any other provision of law, there shall be no requirements applicable to a VA health plan with respect to the maintenance of a reserve fund, requirements to reinsure, or payments into any other financial integrity fund other than as established pursuant to paragraph (1).

"(f) In carrying out responsibilities under the Health Security Act, a State (or a State-established entity)—

"(1) may not impose any standard or requirement on a VA health plan that is inconsistent with this section or any regulation prescribed under this section or other Federal laws regarding the operation of this section; and

"(2) may not deny certification of a VA health plan under the Health Security Act on the basis of a conflict between a rule of a State (or State-established entity) and this section or regulations prescribed under this section or other Federal laws regarding the operation of this section.

"§ 7342. Operation of health care facilities within States operating as single payer areas

"(a) In a State (or portion of a State) that under the Health Security Act is operating as a single payer system, Department health care facilities in that State (or portion of a State) shall serve as providers to individuals residing in that State (or portion of a State) who would be eligible to enroll under chapter 18 of this title with a VA health plan if they were residing in an area where there were health plans operating under the Health Security Act. Such facilities may provide those individuals any covered service in the comprehensive benefit package.

"(b) A Department facility providing care to residents of a single payer area pursuant to subsection (a) shall be reimbursed for that care on the same basis as any other provider furnishing the same services in that area.

"(c) A veteran described in section 1831(b) of this title shall be exempt from any otherwise applicable charges for such care. Any other individual provided care pursuant to subsection (a) shall be subject to all applicable requirements respecting copayments, deductibles, and coinsurance. Notwithstanding the preceding sentence, section 1831(c)(3) of this title shall apply to any such charge.

"§ 7343. Health care resource agreements

"(a)(1) In accordance with policies established under subsection (b), an official specified in paragraph (2) may, without regard to any law or regulation specified in paragraph (3), enter into agreements with health care plans, with insurers, and with health care providers, and with any other entity or individual, to furnish or obtain any health-care resource.

"(2) An official specified in this paragraph is any of the following:

"(A) The head of a VA health plan.

"(B) The director of a Department health care facility that is operating as or within a VA health plan.

"(C) The director of a Department health care facility that is operating in a State (or portion of a State) that under the Health Security Act is a single payer area.

"(3) A law or regulation specified in this paragraph is any of the following:

"(A) Section 1703 of this title.

"(B) Any other law or regulation pertaining to—

"(i) competitive procedures;

"(ii) acquisition procedures or policies (other than contract dispute settlement procedures); or

"(iii) bid protests.

"(4) For purposes of this subsection, the term 'health-care resource' has the meaning given that term in section 8152 of this title.

"(b) Policies established by the Secretary under subsection (a) shall include appropriate provisions to ensure that procurements under that subsection are carried out in a manner consistent with (1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse, and (2) the goal of a streamlined process for the acquisition of health-care resources.

"(c) Any proceeds to the Government received from an agreement under subsection (a) shall be credited to the Department of Veterans Affairs Health Plan Fund established under section 1834 of this title and to funds that have been allotted to the facility that furnished the resource involved.

"§ 7344. Administrative and personnel flexibility

"(a) In order to carry out this subchapter, the Secretary may—

"(1) subject to section 1822(c) of this title, carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

"(2) when the Secretary finds it is cost-effective or necessary in order to provide health care services in a timely manner—

"(A) enter into contracts for procurement of any commercially available item at a cost of under $100,000 without regard to any provision of law or regulation (i) requiring competitive procedures; (ii) mandating or giving priority to any source of supply; or (iii) pertaining to protests; and

"(B) enter into contracts without regard to section 8110(c) of this title for the performance of services previously performed by employees of the Department.

"(b)(1) The Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or with health plans under the Health Security Act, or for personnel at facilities operating in a State (or portion of a State) that under the Health Security Act is a single payer area, whenever the Secretary considers such action necessary in order to carry out the terms of that Act, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

"(2) In establishing alternative personnel systems or procedures under this subsection, the Secretary shall include the following:

"(A) A system that ensures that applicants for employment and employees are appointed, promoted, and assigned on the basis of merit and fitness.

"(B) An equal employment opportunity program.

"(C) Compensation systems which will be used to set rates of pay that are competitive with rates of pay paid by health-care providers other than the Department and that take into consideration the difficulty, responsibility, and qualification requirements of the work performed.

"(D) A formal performance appraisal system.

"(E) A system to address unacceptable conduct and performance by employees, including a general statement of violations, sanctions, and procedures which shall be made known to all employees, and a dispute resolution procedure.

"(F) A formal policy regarding the accrual and use of sick leave and annual leave.

"(c) Subject to any provisions of the Health Security Act relating to, or placing limitations on, the marketing of health plans and information that must be provided by health plans, the Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans.

"§ 7345. Veterans Health Care Transition Fund

"(a) For each of fiscal years 1995, 1996, and 1997, the Secretary of the Treasury shall credit to a special fund (in this section referred to as the 'Fund') of the Treasury an amount equal to—

"(1) $1,250,000,000 for fiscal year 1995;

"(2) $850,000,000 for fiscal year 1996; and

"(3) $1,950,000,000 for fiscal year 1997.

"(b) Amounts in the Fund shall be available to the Secretary only for the VA health plans authorized under this chapter. Such amounts are available without fiscal year limitation for costs of commencing operation of VA health plans, including consulting services, equipment, market-

ing, and other costs, minor construction, and (subject to section 8104 of this title) major construction.

"(c) The Secretary shall submit to Congress, no later than March 1, 1997, a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, national health care reform under the Health Security Act during fiscal years 1995 and 1996. The report shall include a discussion of—

"(1) the adequacy of amounts in the Fund for the operation of VA health plans;

"(2) the quality of care provided by such plans;

"(3) the ability of such plans to attract patients; and

"(4) the need (if any) for additional funds for the Fund in fiscal years after fiscal year 1997.

"§ 7346. Funding provisions: grants and other sources of assistance

"The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to facilities of the Department or to health plans operated by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"7341. Organization of health care facilities as health plans.
"7342. Operation of health care facilities within States operating as single payer areas.
"7343. Health care resource agreements.
"7344. Administrative and personnel flexibility.
"7345. Veterans Health Care Transition Fund.
"7346. Funding provisions: grants and other sources of assistance.

"SUBCHAPTER V—RESEARCH CORPORATIONS".

SEC. 8103. ELIGIBILITY FOR CHAPTER 17 CARE.

(a) NURSING HOME CARE.—Section 1710(a)(1) of title 38, United States Code, is amended by inserting "(or, in the case of a veteran described in subparagraph (A) or (D) below, shall furnish nursing home care)" after "may furnish nursing home care".

(b) OUTPATIENT CARE FOR ENROLLED VETERANS.—Paragraph (1) of section 1712(a) of such title is amended—

(1) by striking out "and" at the end of subparagraph (C);

(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon; and

(3) by adding at the end the following:

"(E) to any veteran described in section 1831(b) of this title who is enrolled under section 1811 of this title and the Health Security Act with a VA health plan (as defined in section 1801 of this title), for any disability to the extent that care and treatment of that disability is not included within the comprehensive benefit package (as defined in section 1801 of this title);".

(c) OBVIATE-THE-NEED OUTPATIENT CARE.—(1) Paragraph (2) of such section is amended by striking out "The Secretary" and all the follows through "this subsection—" and inserting in lieu thereof "Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—".

(2) Paragraph (4) of such section is amended by striking out "medical services for a purpose described in paragraph (5) of this subsection" and inserting in lieu thereof ", to the extent that facilities are available, such medical services as the Secretary determines are needed".

(3) Such section is further amended—

(A) by striking out paragraph (5); and

(B) by redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively.

(d) CONFORMING AMENDMENTS.—(1) Section 1701(6)(A)(i) of such title is amended by striking out "(except under the conditions described in section 1712(a)(5)(A) of this title)".

(2) Section 1701(6)(B)(i)(II) of such title is amended by striking "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1712".

(3) Section 1703(a)(2)(B) of such title is amended by striking out "for a purpose described in section 1712(a)(5)(B) of this title" and inserting in lieu thereof "to complete treatment incident to hospital, nursing home, or domiciliary care that has been provided by the Department".

(4) Section 1712A(b)(1) of such title is amended by striking out "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1703(a)(2)(B)".

SEC. 8104. AUTHORITY TO PROVIDE HEALTH CARE FOR HERBICIDE AND RADIATION EXPOSURE.

(a) AUTHORIZED INPATIENT CARE.—Section 1710(e) of title 38, United States Code, is amended to read as follows:

"(e)(1)(A) Subject to paragraph (4), a herbicide-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for any disease specified in subparagraph (B).

"(B) The diseases referred to in subparagraph (A) are those for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined—

"(i) that there is sufficient evidence to conclude that there is a positive association between occurrence of

the disease in humans and exposure to a herbicide agent;

"(ii) that there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but such evidence is limited in nature; or

"(iii) that available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

"(2) A radiation-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for—

"(A) any disease listed in section 1112(c)(2) of this title; and

"(B) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

"(3) Subject to paragraph (4), a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability which becomes manifest before October 1, 1996, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

"(4) Hospital and nursing home care may not be provided under or by virtue of paragraph (1) after September 30, 1996, or, in the case of a veteran described in paragraph (3), after September 30, 1998.

"(5) For purposes of this subsection and section 1712 of this title—

"(A) the term 'herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam during the Vietnam era, and (ii) who the Secretary finds may have been exposed during such service to a herbicide agent;

"(B) the term 'herbicide agent' has the meaning given that term in section 1116(a)(4) of this title; and

"(C) the term 'radiation-exposed veteran' has the meaning given that term in section 1112(c)(4) of this title.".

(b) AUTHORIZED OUTPATIENT CARE.—Section 1712 of such title is amended—

(1) in subsection (a)(1) (as amended by section 8103(b)), by adding at the end the following:

"(F) during the period before October 1, 1996, to any herbicide-exposed veteran for any disease listed in section 1710(e)(1)(B) of this title; and

"(G) to any radiation-exposed veteran for any disease covered under section 1710(e)(1)(C) of this title."; and

(2) in subsection (i)(3)—

(A) by striking out "(A)"; and

(B) by striking out ", or (B)" and all that follows through "title".

(c) SAVINGS PROVISION.—The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital care, nursing home care, and medical services in the case of any veteran furnished care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions.

SEC. 8105. EXTENSION OF AUTHORITY TO PROVIDE PRIORITY OUTPATIENT HEALTH CARE FOR EXPOSURE TO ENVIRONMENTAL HAZARDS.

Section 1712(a)(1)(D) of title 38, United States Code, is amended by striking out "December 31, 1994, for any disability" and inserting in lieu thereof "October 1, 1998, for any disability which becomes manifest before October 1, 1996,".

SEC. 8106. REPORT ON WAIVING COST-SHARING FOR CERTAIN MEDICAL CARE FOR DEPENDENTS OF PERSIAN GULF VETERANS WHO MAY HAVE BEEN EXPOSED TO ENVIRONMENTAL HAZARDS.

(a) REPORT.—The Secretary of Veterans Affairs shall submit to Congress a report on the desirability and the feasibility of waiving any requirement for cost-sharing in the case of medical care described in subsection (b) that is provided by a VA health plan under chapter 18 of title 38, United States Code (as added by section 8101), to an individual who is a VA enrollee enrolled under family-member eligibility under section 1813 of that chapter.

(b) PERSIAN GULF WAR ILLNESS.—Medical care referred to in subsection (a) is medical care provided to a family member of a veteran described in subparagraph (C) of section 1710(e)(1) of title 38, United States Code, for any disease or disability occurring in that family member which the Secretary finds may be related to the service of the veteran in the Southwest Asia theater of operations during the Persian Gulf War.

(c) MATTERS TO BE CONSIDERED.—In preparing the report under subsection (a), the Secretary shall consider relevant studies, including those that have been (or that are being) conducted by the Department of Veterans Affairs, the Department of Defense, the National Institutes of Health, the National Academy of Sciences, and private health care providers.

(d) SUBMISSION OF REPORT.—The report under subsection (a) shall be submitted not later than 60 days after the date of the enactment of this Act.

SEC. 8107. STUDY OF THE EFFECT OF TELEMEDICINE ON THE DELIVERY OF VA HEALTH CARE SERVICES.

(a) IN GENERAL.—During each of fiscal years 1995 through 1997, the Secretary of Veterans Affairs shall carry out a study of the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals who are eligible for enrollment in a Department of Veterans Affairs health care plan.

(b) REPORTS.—Not later than 120 days after the date of the enactment of this Act and annually thereafter through 1998, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report, including descriptions of the telemedicine applications benefiting veterans, relating to the study conducted under subsection (a).

(c) CONSULTATION.—Each study under subsection (a) shall be carried out in consultation with the Secretary of Health and Human Services, the Secretary of Defense, the Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

SEC. 8108. EFFECTIVE DATE OF COVERAGE FOR HIGH-PRIORITY VETERANS.

Notwithstanding any other provision of this Act, the provisions of the amendments made by this subtitle shall take effect with respect to veterans described in section 1831(b) of title 38, United States Code, as added by section 8101, on October 1, 1995. The Secretary of Veterans Affairs shall take such steps as necessary to implement those provisions with respect to those veterans by that date.

INTRODUCTION

The Committee has amassed a substantial hearing record on the role of the Department of Veterans Affairs under a national health care reform.

On April 28, 1993, the Subcommittee on Hospitals and Health, received testimony on draft legislation from the Department of Veterans Affairs (VA) regarding the impact of national health care reform on VA health care. Those testifying included the Honorable John D. Rockefeller, IV, Chairman, Committee on Veterans' Affairs, United States Senate; Mr. Al Zamberlan, Regional Director, Central Region, Veterans Health Administration, Department of Veterans Affairs (VA); Mr. Fred Malphurs, Director, VA Medical Center, Albany, NY; Mr. Malcom Randall, Director, VA Medical Center, Gainesville, FL: Itamar B. Abrass, M.D., Chair, VA Geriatrics and Gerontology Advisory Committee and Professor of Medicine and Head, Division of Gerontology and Geriatric Medicine, University of Washington; D. Earl Brown, Jr., M.D., Abt Associates and former Associate Deputy Chief Medical Director, VA; Gerald N. Burrow, M.D., Association of American Medical Colleges and Dean, Yale University School of Medicine; Kenneth I. Shine, M.D., President, National Institute of Medicine; Mr. Michael Brinck, Director of Veterans Service/Legislation, AMVETS, accompanied by Mr.

Noel Woosley, National Service Director; Mr. Dennis Cullinan, Assistant Director, National Legislative Service, Veterans of Foreign Wars; Mr. Paul Egan, Executive Director, Vietnam Veterans of America; Mr. David Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; Mr. John Hanson, Director, National Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Gordon Mansfield, Executive Director, Paralyzed Veterans of America; and Mr. Charles Williams, Executive Director, American Ex-Prisoners of War. Providing statements were the Blinded Veterans Association and the Air Force Sergeants Association.

On June 3 and 4, 1993, the Subcommittee on Hospitals and Health Care held a field hearing in Dublin and Atlanta, GA, and heard testimony on VA's role in national health care reform as well as VA medical care delivery in Georgia. The Subcommittee received testimony from the Honorable Michael A. "Mac" Collins, a representative in Congress from the State of Georgia; Mr. Richard P. Miller, Regional Director, Southern Region, Veterans Health Administration, VA, accompanied by Dr. John Higgins, Southern Region Chief of Staff; Mr. Charles Wickes, Director, Atlanta Regional Office, Veterans' Benefits Administration; Mr. William Edgar, Director, VA Medical Center, Dublin, GA; Mr. Thomas Ayres, Director, VA Medical Center, Augusta, GA; Mr. Larry Deal, Director, VA Medical Center, Atlanta, GA; W. Douglas Skelton, M.D., Dean, Mercer University School of Medicine; Jeffrey Houpt, M.D., Dean, Emory University School of Medicine; Mr. Pete Wheeler, Commissioner, Department of Veterans' Services, State of Georgia; Mr. Pat Phillips, Commander, Department of Georgia, The American Legion; Mr. A.V. Akin, Service Officer, Department of Georgia, The American Legion; Mr. Jackie D. Hanshew, Commander, Department of Georgia, Disabled American Veterans accompanied by Mr. James Phagan, Hospital Service Coordinator; and Mr. William Coward, Hospital Service Coordinator, Disabled American Veterans accompanied by Mr. Avery Swain, Southern Area Executive Committeeman, Disabled American Veterans.

The Subcommittee met on October 14, 1993, and received testimony on the role VA would play under the President's proposed health care reform plan and the manner in which veterans would be served under that plan. Witnesses were Judith Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; Honorable Jesse Brown, Secretary of Veterans Affairs, accompanied by John T. Farrar, M.D., Acting Under Secretary for Health, Veterans Health Administration; Victor P. Raymond, Ph.D., Assistant Secretary for Policy and Planning; D. Mark Catlett, Assistant Secretary for Finance and Information Resources Management; and Ms. Mary Lou Keener, General Counsel.

On November 18, 1993, the Subcommittee received testimony on the President's proposal for health care reform from Marvin Dunn, M.D., Dean, School of Medicine, University of South Florida (representing the Association of American Medical Colleges); Thomas L. Garthwaite, M.D., President, National Association of VA Chiefs of Staff and Chief of Staff, Zablocki VA Medical Center, Milwaukee, WI; Mr. Frank Buxton, Deputy Director, National Veterans Affairs

and Rehabilitation Commission, The American Legion; Mr. Dennis Cullinan, Deputy Director, National Legislative Services, Veterans of Foreign Wars; Mr. David W. Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; Mr. Michael F. Brinck, National Legislative Director, AMVETS; Mr. Gordon Mansfield, Executive Director, Paralyzed Veterans of America; Samuel V. Spagnolo, M.D., President, National Association of VA Physicians and Dentists; Ms. Bette L. Davis, President, The Nurses' Organization of Veterans Affairs; Ms. Alma Lee, President, VA Council, American Federation of Government Employees; Charles Prigmore, Ph.D., Senior Vice Commander and Legislative Chairman, American Ex-Prisoners of War, accompanied by Mr. William E. Bearisto, National Commander; and Mr. Paul Egan, Executive Director, Vietnam Veterans of America.

On March 8, 1994, the Subcommittee held a hearing on H.R. 3808, legislation to preserve VA's flexibility in meeting its medical workforce needs under national health care reform and draft legislation to authorize a pilot program for VA participation in State health reforms. Testimony was heard from Elwood Headley, M.D., Acting Deputy Under Secretary for Health, Veterans Health Administration, VA, accompanied by Ms. Mary Lou Keener, General Counsel; Patricia O'Neil, Special Assistant to the Assistant Secretary for Policy and Planning and States' Health Care Reform Cluster Leader, and Mr. Sanford Garfunkel, Associate Chief Medical Director for Operations, Veterans Health Administration; Robert Petzel, M.D., Chief of Staff, VA Medical Center, Minneapolis, MN; Mr. Malcom Randall, Director, VA Medical Center, Gainesville, FL; Mr. Gary De Gasta, Director, VA Medical and Regional Office Center, White River Junction, VT; Mr. Joseph Manley, Acting Director, VA Medical Center, Seattle, WA; Mr. Frank Buxton, Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Dave Gorman, Deputy National Legislative Director, Disabled American Veterans; Mr. James Magill, Director, National Legislative Service, Veterans of Foreign Wars; Mr. Michael Brinck, National Legislative Director, AMVETS; Mr. Russell Mank, Legislative Director, Paralyzed Veterans of America; Mr. Paul Egan, Executive Director, Vietnam Veterans of America; Mr. Tom Miller, Director of Governmental Relations, Blinded Veterans Association; John Burton, D.D.S., Secretary-Treasurer, National Association of VA Physicians and Dentists; Ms. Bette Davis, President, The Nurses' Organization of the VA; and Mr. Chapin E. Wilson, Jr., attending in the absence of Mr. Bobby Harnage, National Secretary-Treasurer, American Federation of Government Employees.

On March 23, 1994, the Subcommittee held a hearing on the VA's plans for implementing health care reform and current and future construction planning as it relates to health care reform in the VA. Testimony was provided by Elwood Headley, M.D., Acting Deputy Under Secretary for Health, Veterans Health Administration, VA, accompanied by Ms. Mary Lou Keener, General Counsel, VA; Ms. Karen Walters, Deputy Director for Legislation and Policy, National Health Care Reform Program Office; and Mr. Charles A. Milbrandt, Acting Associate Chief Medical Director for Resources, Veterans Health Administration, accompanied by Mr. Robert

Neary, Deputy Associate Chief Medical Director for Construction Management, Veterans Health Administration, and Ms. Linda Kurtz, Director, Facilities Liaison Office, Veterans Health Administration.

On May 11, 1994, the Subcommittee marked up an amendment that incorporated the provisions of H.R. 4124. The amendment was in the form of a substitute to subtitle B of title VIII, of H.R. 3600. The amendment, as amended, passed by a vote of 18-1 and was recommended to the full Committee.

On June 29, 1994, the Subcommittee on Oversight and Investigations held a hearing on barriers and risks associated with VA health care competitiveness and the Health Security Act. The Subcommittee heard testimony from Mr. Robert A. Perreault, Director, Health Care Reform Office, Veterans Health Administration, VA, accompanied by Mr. Gary Krump, Acting Assistant Secretary for Acquisitions and Facilities, Ms. Nora Egan, Associate Deputy Assistant Secretary for Human Resources Management, Mr. Audley Hendricks, Assistant General Counsel, and Mr. William Thomas, Assistant General Counsel; and Mr. David P. Baine, Director, Federal Health Care Delivery Issues, Health, Education, and Human Services Division, U.S. General Accounting Office, accompanied by Mr. James R. Linz, Assistant Director, Health, Education, and Human Services Division, and Mr. Terry Saiki, Senior Evaluator, Seattle Office.

The Subcommittee on Oversight and Investigations also held additional hearings on issues related to health reform. These included a hearing on April 20, 1994, regarding veterans' perceptions of VA health care and a hearing on July 21, 1993, regarding veteran access to VA outpatient care and related issues.

The full Committee met on July 21, 1994; adopted amendments to the Subcommittee amendment; and ordered the Committee amendments, in the form of a substitute, to subtitle B of title VIII, H.R. 3600, reported favorably to the House by a unanimous voice vote.

Summary of the Reported Amendment

1. Enrollment.—a. Each veteran who is an eligible individual within the meaning of section 1001 of the Health Security Act (including medicare-eligible veterans) may enroll with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the VA shall enroll with a VA health plan.

b. Eligible for enrollment also are Civilian Health and Medical Program of the VA (CHAMPVA) eligibles.

c. Eligible for enrollment are veteran family members. If the enrollee chooses to enroll in the VA health plan with family members, all family members must enroll.

d. Family members shall be subject to payment of premiums, deductibles, copayments, and coinsurance as required by the Health Security Act.

e. Family members who have enrolled in a VA health plan shall not lose eligibility for renewal enrollments by the death of the veteran.

2. Benefits.—a. VA shall furnish enrolled individuals the items and services provided in the comprehensive benefit package under the Health Security Act.

b. In addition, veterans remain eligible for those services provided under chapter 17, which are not included in the comprehensive benefit package (whether enrolled in a VA health plan or not.)

c. The VA shall preserve the specialized treatment and rehabilitative needs of disabled veterans (including SCI, blind, and mentally ill) within distinct programs or facilities dedicated to these specialized needs. The Secretary shall submit an annual report to the House and Senate Veterans Affairs Committees describing the actions taken in carrying out the preservation of the specialized treatment and rehabilitative programs.

d. A VA health plan may not provide an abortion either directly or by contract except in the case of rape, incest, or danger to the mother's life.

3. Supplemental benefits packages and policies.—A VA health plan may offer supplemental health benefits packages and supplemental cost sharing policies but may not charge veterans for services which VA is required to furnish them.

4. Limitation regarding veterans enrolled with health plans outside the VA.—A veteran not enrolled in a VA health plan where one is operating may receive items and services in the comprehensive benefit package only if the plan is reimbursed in accordance with the Health Security Act, except that a veteran, who is treated for a service-connected disability requiring a specialized treatment capacity for which the VA has particular expertise, shall be exempt from cost-sharing obligations.

5. Cost-sharing obligations.—a. "Core" veterans (the service-connected, low-income, former prisoners of war, and WWI) who enroll for a VA health plan shall not be liable to pay premiums, copayments, or other charges for VA-provided services covered under the "comprehensive benefits package."

b. CHAMPVA beneficiaries who enroll for a VA health plan shall not be liable for premium payments, but are liable for copayments, deductibles, and coinsurance.

c. Veterans who have special eligibility for care of diseases which may be linked to presumed exposure to toxic substances (Agent Orange, radiation, Persian Gulf exposures) and who enroll with a VA health plan, shall not be liable for copayments, deductibles, or coinsurance in connection with care of those covered conditions.

d. Self-employed service-connected veterans who enroll in a VA plan shall not be liable for premium payments.

6. Medicare reimbursement.—In the case of care provided to medicare-eligible veterans who are other than "core veterans", the Secretary of Health and Human Services shall reimburse VA in the same amounts as other Medicare providers.

7. Cost-recovery.—VA has the right to recover from supplemental insurance policies (other than for care for a service-connected disability.)

8. Health Plan Fund.—a. A revolving fund shall be established in the Treasury into which shall be credited any amount VA receives by reason of (1) individual enrollments with a VA health plan (including premiums, copayments, third-party reimburse-

ments, etc.) and (2) a VA health plan's providing care. Amounts in the fund are available for all expenses, direct and indirect, related to operating health plans and delivering services in the comprehensive benefits package and any supplemental benefits package or policy offered by a VA health plan.

b. Amounts deposited in the fund that are attributable to premium payments for "core" veterans shall be covered into the General Fund of the Treasury.

9. Guaranteed funding for "core" veterans.—a. The Secretary of the Treasury shall make quarterly payments into the Health Plan Fund of amounts certified by the Secretary of Veterans Affairs as constituting the product of (1) the projected number of "core" veteran enrollees and the "capitated enrollment amount" for that fiscal year. The Secretary shall adjust future certifications to account for (1) differences between the actual and projected number of enrollees and (2) data which produces a more accurate capitated enrollment amount.

b. The initial capitated enrollment amount is to be determined by dividing (1) the annual full cost incurred by the Department in providing those services specified to be included in the comprehensive benefits package (based on the most recent cost data available and adjusted for inflation based on the Bureau of Labor Statistics' medical care consumer price index) by (2) the total number of "core" veterans who received those services. In tabulating VA's total annual full cost for these purposes the Secretary shall include the amount appropriated for FY 1994 for VA medical and prosthetic research.

c. VA shall develop the methodology for determining the initial capitated enrollment amount in consultation with the Comptroller General.

d. The initial capitated enrollment amount, as adjusted for the rate of medical inflation, shall apply for the first five fiscal years during which VA operates VA health plans. After the third year, VA shall report to Congress on actions needed to change the annual capitated enrollment amount by the end of the fifth year.

10. VA facilities not operating as part of a health plan.—VA facilities not operating within a health plan under the Health Security Act shall operate in accordance with the provisions of chapter 17 of title 38, United States Code.

11. Establishment of VA health plans.—a. The Secretary shall organize and prescribe regulations establishing standards for the operation of VA facilities as or within health plans under the Health Security Act.

b. All VA facilities within a geographic area or region may be organized to operate as a single health plan or operate as several health plans.

c. A State may not impose any standard or requirement on a VA health plan that is inconsistent with the VA regulation or other Federal laws.

d. A State may not deny certification of a VA health plan on the basis of a conflict between a rule of a State or health alliance and VA's regulations and Federal laws.

e. Health insurance purchasing entities shall offer any VA health plan operating in the applicable geographic area as an option to qualified individuals.

f. Any health insurance program provided for Federal employees shall include VA health plans as enrollment options; premiums under any such program shall be paid to a VA health plan in the same manner as to any other provider.

g. An employer's obligations under the Health Security Act as they apply to a VA health plan and such employer's veteran employees shall be the same as those applicable to other employees and other health plans.

h. The Secretary, in consultation with the Comptroller General, shall take appropriate steps to ensure the financial solvency and stability of each VA health plan, and may purchase insurance as a means of insuring against such risk.

12. Health care resource agreements.—a. A VA health plan or the director of a VA health care facility that is operating as or within a VA health plan may enter into agreements with health care plans, insurers, and providers to furnish or obtain health care resources.

b. Any proceeds to the Government from such an agreement shall be credited to the Department of Veterans Affairs Health Care Fund established under this title and to funds that have been allotted to the facility that furnished the resource involved.

13. Health Care Transition Fund.—The Secretary of the Treasury shall credit to a special fund $1.25 billion for FY 95, $850 million for FY 96, and $1.95 billion for FY 97 to be available without fiscal year limitation for costs of starting-up health plans (including consulting services, equipment, marketing, and construction.)

14. Grant support.—Notwithstanding otherwise applicable limitations, VA may apply for and accept any grant or other source of funding intended to meet the needs of special populations if such funds will be used through a VA facility operating as or within a health plan.

15. Eligibility Reform.—a. VA shall furnish nursing home care to veterans who are 50 percent or more service-connected disabled or who require such care for a service-connected condition.

b. VA *shall* provide any "core" veteran who enrolls with a VA plan with any needed outpatient services which are not covered or not fully covered under the comprehensive benefits package.

c. In the case of veterans who do not enroll with VA health plans or who are not "core" veterans, the Secretary *may* provide needed outpatient services not covered or not fully covered under the comprehensive benefits package.

16. Health Care for Herbicide and Radiation exposure.—a. Veterans who served in Vietnam during the Vietnam era who VA finds may have been exposed to a herbicide agent are eligible for hospital, nursing home care, and outpatient care through September 30, 1996, for any disease which the National Academy of Sciences has found (or subsequently finds) either some evidence of, or insufficient evidence to permit a conclusion as to, an association between occurrence of the diseases in humans and exposure to a herbicide.

b. Veterans who have been radiation-exposed are eligible for hospital, nursing home, and outpatient care for any disease for which the Secretary determines there is credible evidence of an association between the occurrence of the diseases in humans and exposure to ionizing radiation.

c. Veterans who have received VA care under special eligibility provisions are "grandfathered."

17. Priority Health Care for Exposure to Environmental Hazards.—Veterans who the Secretary finds may have been exposed to a toxic substance or environmental hazard while serving on active duty in the Persian Gulf War are eligible for hospital and nursing home care and outpatient care through September 30, 1998, for any disability which becomes manifest before October, 1996, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

18. Telemedicine in the delivery of VA health care.—The VA, in consultation with the Secretary of HHS, Secretary of DoD, Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President, will study and report to the Committees on Veterans Affairs, the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals eligible for enrollment in a VA health care plan.

Background

"The Department of Veterans Affairs health-care system is an American Health asset at risk." With that stark introductory warning, the Commission on the Future Structure of Veterans Health Care opened its report to the Secretary of Veterans Affairs in November 1991, recommending "a set of integrated and mutually dependent policies that can rescue the VA health-care program."

Among the reforms proposed by this blue-ribbon panel was an overhaul of VA's system of health care eligibility to assure that service-connected and poor veterans receive the full range of needed health-care services. The Commission recognized, however, that "improvements in access and simplified eligibility require adequate and stable funding", and that "during the past decade, VA's medical budget has been neither adequate nor stable . . . As a result, it has become more difficult for VA to deliver state-of-the-art health care to veterans," or to support VA's other health missions. The Commission strongly urged "funding commensurate with the clear health-care delivery obligations of VA, including provisions to account for annual inflation in the overall health sector." Significantly, the Commission called for funding VA health care from sources other than congressional appropriations:

> Currently, VA receives the vast majority of its funds through direct Congressional appropriations. Because the Federal deficit has redefined the fiscal debate, however, we believe that VA will find it difficult, if not impossible, in the long run to obtain significant increases in funds through direct appropriations. Recognizing the difficulties of achieving higher appropriations, we recommend that the

Secretary pursue other sources of funding for VA health-care programs.

Just two years later, proponents of an ambitious national health care reform proposal, introduced as H.R. 3600, identified that bill as a reform which would honor the nation's commitment to its veterans. At its core, the President's plan was identified as a plan which "will guarantee comprehensive health benefits for all Americans, no matter who they are or where they live" and which "will preserve veteran benefits, increase veteran health care system flexibility, and maintain specialized services." (*The Health Security Plan Briefing Book*) In the critical area of funding, the Administration promised that "VA would be permitted to retain funds recovered from third-party payers", and that "VA managers will be allowed to control budgets without traditional restrictions of line-items or earmarked funds".

The President's plan for VA health care set the framework for this Committee. While very welcome, introduction of a national health care plan which proposes comprehensive VA health care reform represents, from the vantage point of this Committee and its record of advocacy, a long-overdue step. It is, however, a step that is not without risk.

HISTORICAL DEVELOPMENT

This Administration's recognition of the strength and promise of the VA health care system comes at a historic juncture, and offers the promise of moving the Department in new directions. The changes being proposed are far-reaching and for some even threatening. But like medical care itself, the VA health care system's history is one of change and adaptation.

Historians can trace the roots of the Department of Veterans Affairs medical system to the colonial period, but others see World War I as the first major step in that system's development. In 1917, Congress in amending the War Risk Insurance Act first authorized "reasonable hospital services to veterans with service-connected conditions". But not until war's end was provision made for the establishment of hospitals specifically to serve the veterans of that war. In 1919, with Public Law 326, Congress vested the Public Health Service with that responsibility, transferred certain military hospitals to the service and authorized a number of others. While the number of beds it operated grew exponentially, the Service, nevertheless, relied heavily on contract care with civilian hospitals to carry out its mission.

The system we know today evolved gradually and, not surprisingly, has been influenced by the country's experience with war. Among the first of the series of institutional changes that have occurred was the creation of a Veterans Bureau in 1921 which brought most veterans' benefits under the administration of a single agency. Hospital operations were transferred to the Bureau a year later pursuant to an Executive Order. (The establishment of a single agency responsible for administering all veterans' benefits did not come about until 1930 with the consolidation of the "new" veterans bureau with the National Homes for Disabled Volunteer Soldiers and the Bureau of Pensions into the Veterans Administration.)

Not only were important institutional changes made in the immediate post-war years, but legislation enacted during this period set the broad framework of the role VA medical care would play for the next 25 years and beyond. That law, the World War Veterans Act of 1924, authorized the Director of the Veterans Bureau to provide hospital care to any honorably discharged veteran wherever facilities were available. Like legislation two years earlier providing for hospitalization of Spanish-American War veterans, Congress did not condition this benefit on the cause or origin of a veteran's disability. VA health care would not be limited to care of service-connected conditions.

During the 1930's, the nature of the VA's medical activities grew and the proportion of patients with nonservice-connected disabilities continued to increase. Significantly, the characteristics of VA patients changed as well. During the 1930's, more than half of VA-hospitalized veterans suffered from neuropsychiatric conditions, 31 percent were general medical and surgical patients, and 13 percent suffered from tuberculosis (down from more than 40 percent in the 1920's). Construction planning during this period was heavily focused on meeting the needs of psychiatric patients.

By the beginning of World War II, a nationwide system of VA hospitals had been constructed, but none was accredited for residencies or internships and many were in remote locations. The location of VA's hospitals was related to the perceived needs of the large numbers of psychiatric and tuberculosis patients VA treated. TB specialists felt patients should be treated away from cities; likewise specialists in treating psychiatric disease regarded farming and related activities as a major form of therapy and thus extensive acreage was considered necessary for a mental hospital. While most of the general medical and surgical hospitals were located near metropolitan areas, when possible, so consultants would be available, no thought was given to affiliating with medical schools.

In 1945, President Roosevelt named General Omar Bradley to head a VA that had been under attack as not capable of meeting the needs of the vast numbers returning from overseas. Bradley and his staff instituted sweeping changes in the agency's medical service, reorganizing it into a Department of Medicine and Surgery. Quality of care was substantially improved through a three-point program: expanding VA's medical care mission to include both medical research and education and training; establishing a program of affiliation with medical schools to attract outstanding medical personnel; and obtaining additional funds for staffing and facilities. The implementation of these far-reaching developments coincided with dramatic increases in VA's patient workload, and led the way to profound improvement in the quality of VA care, ambitious construction of new hospitals, affiliation with top medical schools across the country, and dramatic expansion in the array of VA medical services and education and research programs.

A CALL FOR CHANGE

Veterans continue to benefit from the foresight and commitment of the architects of the VA health care system, which today provides hospital care to approximately 550,000 veterans and outpatient services to 2.2 million veterans annually. That care is fur-

nished in facilities which provide training to approximately half of the country's supply of physicians and which conduct close to $1 billion in medical, prosthetics, and health services research annually.

Veterans have not been the only beneficiaries of VA health care. VA has been a leader in such fields as long-term care, mental health care, and rehabilitation. It has spawned major innovation and development in the field of prosthetics and research advances ranging from the concept of the CAT scan and MRI to the first successful drug therapies for tuberculosis and schizophrenia.

Advances and achievements in VA health care have occurred in a system which has also faced significant problems and continues to confront vast challenges. Among the most persistent dilemmas for VA has been the gap between the needs of its patients and availability of funds to meet those needs. Adjusted for inflation, VA health care funding has been virtually flat for more than a decade, a period during which Congress has mandated VA to take on such new responsibilities as establishing a network of centers to counsel Vietnam veterans, combatting homelessness among veterans, providing specialized treatment for post-traumatic stress disorder, providing priority treatment for Persian Gulf veterans, and serving as a contingency backup to the Department of Defense. Tight budgets have squeezed system administrators and forced painful choices: between maintaining current operations and beginning to address future needs; between responding aggressively to the needs of America's younger veterans and sustaining service-delivery to those of earlier wars; between maintaining a commitment to costly "state-of-the-art" medicine and advancing other clinical values; between maintaining the strengths of existing facilities and shifting resources to the Sunbelt.

The Administration's proposal that VA constitute its facilities into a system of health plans which offer veterans the option of enrollment calls on VA for the first time to "compete" for patients. Under a system of universal health care coverage, the many veterans who have long turned to VA as a "safety net" would have choices not now available. For VA, the challenges of health care reform include transforming a long-underfunded system to meet the demands of the medical marketplace. The challenge is many-faceted.

VA confronts health care reform with strengths, but also with serious weaknesses. While VA furnishes some 23 million outpatient visits annually, its eligibility law, architecture, and affiliation relationships all play a part in shaping practice patterns which continue to rely heavily on bed-based care. Operating under provisions of law which limit access to outpatient services and which are more readily understandable in terms of budget limitations than clinical considerations, VA generally does not offer expansive programs of primary and preventive care which its likely "competitors" have long furnished. Space limitations and funding constraints often frustrate effective delivery of ambulatory treatment. Lack of sufficient construction funding to convert hospital ward space into clinics and lack of sufficient funds to meet the needs for outpatient staffing contribute to too frequent instances of veteran patients experiencing long waits for treatment.

While VA has operated a national health care system, its facilities differ from community to community. Its history and development shape those facilities, some of which were designed to treat TB or psychiatric patients, while others were designed and constructed decades later to house sophisticated medical equipment and operate in affiliation with nearby academic centers. VA's infrastructure necessarily requires ongoing maintenance and modernization, yet medical care and construction budgets have clearly not kept pace. In recent years, VA officials have defended proposed budgets as "maintaining current service levels". That longstanding emphasis on essentially "staying afloat" has come at a cost in failure to budget adequately for future needs or to address adequately the physical condition of VA facilities. As a result, VA health care facilities continue to face huge backlogs of both medical equipment in need of replacement (a backlog totalling more than $700 million) and unmet maintenance and repair work (totalling some $930 million). Ironically, with aging facilities requiring major construction work, VA construction budgets have not even held to a "current services" level, but have plunged in recent years to levels that have not even kept pace with the construction needs sparked by earthquakes and earthquake threats.

Other serious challenges face the VA health care system. Its managers and supervisors are hampered in their ability to respond quickly and effectively to staffing demands by a too-often inflexible personnel system. In many health care markets, VA has faced significant difficulty in recruitment and retention of qualified employees because of pay scales which are not competitive with salaries offered by private sector providers in the area. In attempting to recruit and retain physicians, for example, VA operates under a pay system tailored to reward subspecialist medical practice disproportionately to general practice. With few fiscal mechanisms to lure primary care physicians and internists at a time that the country is experiencing a shortage of primary care providers, VA is ill-equipped to compete in many markets for physicians trained in primary care. A fast-changing medical marketplace is further complicating VA's staffing dilemma, as more and more insurors and other organizations institute and consolidate managed care systems which rely heavily on primary care providers. A recent General Accounting Office (GAO) report starkly highlights VA's challenge in noting that while about 60 percent of managed care plans' physicians are typically primary care physicians, only about 20 percent of VA's physicians are primary care providers or other generalists.

To establish health plans geared to compete for patients with private-sector options, VA would be embarking on a terrain in which it has little or no experience. The Department also lacks many tools essential to meet that challenge. Its information systems, for example, could not now support the establishment or operation of a managed care plan. VA has established industry standards in developing software to support clinical applications, but has not done comparable work on executive and health plan management, with the result that VA managers do not have systems support comparable to the information systems available to their potential competitors. VA needs to improve further its financial management systems. As GAO noted in a recent report on VA health reform, one

of the most significant barriers facing VA is its "inability to generate accurate cost data on items and sevices that it provides and estimate potential use of health care services." GAO notes that without such data, VA would not be able to set accurate premiums or determine when to contract rather than to provide services directly. VA also lacks a central database on veterans' health care eligibility to enable it to establish a smooth enrollment mechanism under health reform. While such software gaps are not insurmountable, they represent areas where VA needs to invest both capital and effort to catch up with private industry.

Hearings on health care reform before the Subcommittee on Hospitals and Health Care have identified "image" as a major challenge for VA to confront. In some quarters, VA suffers from a perception that its care is of poor quality. While having little basis in fact, this perception dogs VA tenaciously. It survives in spite of the findings issued by the Joint Commission on the Accreditation of Healthcare Organizations whose evaluations of VA facilities have resulted in objective quality scores which have consistently been higher than scores for comparable private sector facilities. As a public institution, VA by its nature must be open to the fullest possible scrutiny. Unfortunately, the institutions with which VA is compared are not similarly open, and problem areas, where they exist, seldom come to public attention. In many communities, negative perceptions about VA are reinforced by conditions beyond the Department's control, such as its physical plant and its budget contraints. Many of its older facilities lack amenities found in newer community facilities. With funding needs far outpacing available Federal dollars, VA managers have understandably lost patient goodwill by budget-driven policies of limiting access to care or cutting services. In some instances, however, VA staff have contributed to a negative climate through insensitivity to the importance of a customer-service orientation.

As potential enrollees, many veterans are likely to assess a VA health plan option by reference to prior experiences with VA care. Perceptions borne of such experiences represent additional challenges for VA. In that connection, it is clear to this Committee that many VA patients have the highest regard for the caring attention they receive in VA facilities. The Committee receives much laudatory correspondence from VA patients. But for other veterans VA health care can be frustrating because of the distance the veteran must travel, the eligibility barriers to full access, or the resource-driven delays they face in seeking care. Few veterans are eligible for comprehensive care from the VA. Only the most seriously disabled, service-connected veterans are eligible for a full range of services including preventive care, and, under existing law, VA may not provide *most* of its patients routine, ongoing outpatient care for chronic but stable medical conditions. This eligibility system is difficult both for veterans to understand and for VA to administer. Moreover, since most veterans are eligible for care only *in* a VA facility, geographic accessibility is an issue for many veterans, particularly the elderly chronically-ill. Use of VA services by elderly veterans living more than 20 miles from a VA facility is significantly less than for elderly veterans who live closer and for younger veterans who live up to 40 miles away. Access to services

even for eligible veterans is hampered further by demand for care which outstrips available resources at many facilities. Veterans often experience long waits not only to get a future appointment but after they report to the clinic for care.

Provisions of the Committee amendment may assist VA in overcoming some of its historic difficulties such as its anachronistic eligibility system. Nevertheless, the Department will still face the considerable challenge of adopting and embracing a customer-focused orientation. For example, VA must make a concerted effort to meet needs of women clients, both the increasing number of women veterans and spouses, who will certainly play key roles in choosing their family's health care providers. VA must successfully address customer service issues if it is to sucessfully compete as the plan of first choice for veterans and their families.

WHO WILL ENROLL IN A VA HEALTH PLAN?

The "competitive" model envisioned by the Health Security Act generally assumes that health plans will attract a diverse group of enrollees, and that the high costs of caring for the chronically ill will be offset by an enrollee pool with a substantial proportion of relatively healthy, young individuals. The VA health plan would not be open to all but it would for the first time authorize higher-income veterans to enroll for VA care. Since these veterans would not have the incentive of cost-free care available to low-income and service-connected veterans, however, there is little basis to believe that VA will attract substantial numbers of higher-income veterans. In fact, it has become increasingly clear that those veterans most likely to enroll for VA care are current users.

Health care in America faces critical issues of access, cost and financing. More than 38 million Americans lack adequate health coverage. At the same time, health cost inflation, rapidly changing medical technology, and emerging medical challenges such as AIDS, are placing severe financial pressures on insurers, providers, and consumers of health care. While all of these pressures confront the Veterans' Health Administration, the VA also faces unique challenges of its own. Because of VA's special role as a health care system devoted to the care of veterans, the unique characteristics of this population profoundly define the extraordinary challenge VA faces. In the health care "marketplace" in which health reform will operate, no other health plan or provider will grapple with the demographic dilemma ahead for the VA.

As such, the age and health status of the veteran population are key factors that will shape the level and nature of future demand upon VA medical care. It is well established that the veteran population is not evenly distributed across all age groups, but rather has substantial waves in certain age cohorts. Of particular significance is the fact that during a period in which experts project an increase in this country's population, the veteran population is projected to *decline* steadily into the next century. By the year 2010, the veteran population is expected to decline by almost 23 percent. Confounding this trend, the veteran population is *aging* at a rate twice that of the rest of the population. According to the 1991 report of the Commission on the Future Structure of Veterans Health Care, 4.4 million veterans will be 75 years of age or older by the

year 2005. By the year 2000, almost 9 million veterans will be 65 or older and will constitute twenty-six percent of all Americans over the age of 65; by this same date, 1.3 million veterans will be 85 or older.

While the makeup of the veteran population has extraordinary implications for the future, the challenge of the aging veteran is a *current reality*. The veterans who use and depend on VA today do not represent a cross section of America. Currently VA treats approximately 8 percent of the country's 27 million veterans. VA data illustrate that its hospital patients are typically male; are older and sicker than private sector patients; are underemployed; and have few alternatives to VA care. This patient population places unique demands on the Department such as range and frequency of services sought.

VA's own data show that 66 percent of current VA health care system users report poor or fair health status; the same percentage report disabilities which prevent them from working; 50 percent have annual family income below $10,000; only 16 percent are employed full time. Of those treated as VA outpatients, 40 percent report poor or fair health status, 30 percent report disabilities which prevent them from working; 30 percent have annual family income below $10,000; and only 40 percent are employed.

A March 1994 GAO analysis profiling veterans who used VA medical centers confirms the VA data. Matching Internal Revenue Service information returns against VA patient treatment records for 1991 (the latest year for which tax returns were available at the time the analysis was begun), GAO developed a profile of veterans using VA medical centers. GAO found, for example, that of the 2.2 million veterans (service-connected and non-service-connected) who used VA centers in 1991, two-thirds had family incomes under $20,000. The majority of veterans in both groups had incomes under $20,000—58 percent of the service-connected (SC) and 75 percent of the non-service-connected (NSC). Seventeen percent of the SC veterans had incomes less than $5,000 compared to 28 percent of the NSC's. Forty-nine percent of the NSC veterans and 34 percent of the SC veterans had a family income under $10,000. In addition, 87 percent of the unmarried veterans had incomes below $20,000.

GAO also found that veterans 65 and older were the largest age group of those using VA medical centers. In addition, of those veterans under the age of 65 who used the VA health care system, more than 20 percent had incomes *under $2,500*. GAO data also showed that of the 550,000 veterans who received VA inpatient care in 1991 most had incomes under $10,000, with 60 percent of those institutionalized for more than 21 days having incomes below $10,000. About 40 percent of the 2.2 million veterans were employed and 45 percent were retired. Approximately 16 percent of the VA users had dependents other than a spouse. This profile of VA users differs significantly from the typical family profile for the general population.

These data are an indication of the challenges ahead for the VA health care system. As people age—particularly as they age beyond 65—they require progressively more health care. VA data, for example, show that veterans age 65—74 use VA hospital and out-

patient care twice as often as those younger than 55. Those veterans older than 75 use hospital care 75 percent more frequently than those in the 55—64 age group. Although this increased use of VA hospital care with advancing age is dramatic, it is small compared to the increased use of nursing home care. Men ages 85 or older use VA nursing home care *almost 30 times* as often as men ages 55—64. It is expected that under any health care reform scenario, veterans in these age groups will continue to seek at least this same level of care.

Furthermore, a significant number of VA health care system users over age 65 (12 percent) do not qualify for coverage under the Medicare program. Those system users who are ineligible for Medicare include many who who have not worked enough quarters to qualify because of mental illness, substance abuse, or other significant disabilities for much of their adult life. Thus, these veterans fall through the Medicare "safety net" at a time when their health care needs are increasing.

Such an aging patient population places heavy health care demands on the VA medical care system. With aging, health care problems increase in number, complexity, and duration. In aging persons, chronic illnesses, such as Alzheimer's disease, stroke, heart failure, arthritis, and vision failure are characterized by marked increases in episodes of acute care and are often accompanied by complications. A patient's age, sex, and socio-economic status have also been linked to differences in the cost of health care. Currently, two of every five discharges from VA medical centers are patients age 65 years or older.

Among discharges of patients under 55, one of every five suffers from alcohol dependence or abuse. With few exceptions, these veterans have annual incomes of less than $19,000, and many have incomes of less than $10,000. In addition, mental disorders now account for almost one out of every four discharges. Many of the veterans using VA's mental health programs suffer from additional morbidities, such as substance and/or alcohol abuse problems, which add to both the complexity and level of care required to provide effective treatment.

According to the April 1994 GAO study, most of the veterans who use the VA health care system have multiple conditions, many chronic. The most common diagnoses, typically associated with cost-intensive care, are mental disorders, diseases of the circulatory system, diabetes, neoplasms, diseases of the digestive system, respiratory conditions, and diseases of the nervous system. It is apparent that the Veterans Health Administration (VHA) is a chronic care system for poor veterans and that the intensity of diseases and the extent of co-morbidities common to patients in VA are not mirrored in private sector facilities.

Successful treatment of older and poorer veterans, many of whom have chronic and multiple conditions, requires more care and services than care for other people with the same medical condition(s). Elderly and poor patients are more likely to have medical complications or co-morbidities. Oftentimes the medical procedures themselves are no different, but the elderly or poor patient requires more social or nursing services than other people do. The high number of single veterans using the VA system who lack family

and other social support systems places an additional burden on the VA. In accommodatimg its patients' often unique social needs, VA facilities typically have provided longer inpatient stays than would be afforded a healthier population in the community. GAO's recent study concluded that veterans with lower incomes accounted for the majority of inpatient stays. This study showed that veterans with incomes under $10,000 accounted for 50 percent of the shorter stays (less than 7 days), 55 percent of the intermediate stays (8–21 days) and 60 percent of the stays over 21 days. This report further concluded that the aging veteran population will place unique demands on the VA health care system, ranging from acute hospital care to nursing home care to home-based services.

It has become increasingly apparent that VA hospitals across the country are struggling financially under the pressure of budgets. Too often, medical center directors have been placed in the untenable position of seeking to maintain levels of service-delivery without funding support commensurate with those workload goals. As a result of inadequate budgets, VA medical center directors have been forced to delay care and cut back on services, particularly to middle-income veterans who are eligible for care on a cost-sharing basis, and for whom access is subject to space and resource availability. VA data show that only about 4 percent of its current inpatients are higher income nonservice-connected veterans. Resource limits essentially rule out such veterans' access to VA outpatient treatment.

The Committee's surveys, site visits, and hearing testimony have documented this access-to-care problem, and at the same time raise questions about the nature of the population that would enroll with VA for health care coverage if VA were but one option among many. There is substantial reason to question whether previously disenfranchised higher-income veterans would opt for VA care as a preferred choice among competing choices under a health reform such as envisioned under H.R. 3600. In fact, several analyses give weight to the view that *for the foreseeable future, health care reform will not substantially change the composition of veterans who elect to use VA health care.* "Opening up the system to all veterans" is highly unlikely to change significantly the mix of veteran patients who turn to VA for care. The makeup and health care needs of the population that would actually enroll with VA, of course, has profound implications for VA health care.

GAO concluded in an April 1994 report on Veterans Health Care that *veterans using VA services tend to have lower incomes and less private health insurance coverage than veterans who do not use the VA health care system.* The report further showed that only 33 percent of veterans using VA hospitals have private health insurance compared with 81 percent of the overall veteran population. Similarly, over half of veterans using VA services had incomes lower than $10,000. The GAO analysis confirmed the view that veterans with low incomes are more likely to use VA services than are higher income veterans. Such utilization patterns are, in part, a function of existing barriers to care for these higher income non-service-connected veterans. Due to resource constraints over the last decade, many of these veterans have not had access to the system. Further illustrating this point, GAO in its July 1993 report on

Comparisons of VA Benefits With Other Public and Private Programs found that almost 70 percent of all veterans eligible to obtain care from VA facilities can do so only to the extent that space and resources are available after VA meets the needs of service-connected and low-income veterans. Given the existing barriers to treatment in the VA health care system, many of these veterans use other forms of health care coverage such as private insurance and Medicare.

Since current VA patients are much older and poorer and are far more likely to be disabled than other population groups, VA's traditional patient mix differs substantially from that of other health care providers. The Committee has found no evidence to support that health reform would erase that difference.

Several independent analyses do project that under health care reform, VA will see a decline in demand for both inpatient acute care services and outpatient care services. GAO, in its June 1992 report on the *Impact of Alternative Health Insurance on the Demand for VA Care*, concluded that demand for VA inpatient services could drop by about 18 percent if employers were mandated either to provide health insurance coverage for their workers or pay a tax that would be used to obtain the coverage. The report concluded that demand for VA outpatient services could drop by about 9 percent under such scenarios. The Paralyzed Veterans of America (PVA), in its influential 1992 study, *Strategy 2000*, projected that VA inpatient care capacity could be reduced by as much as 50 percent under health care reform as a result of veteran migration to other health care providers. PVA further projected that demand for VA outpatient care could be reduced by as much as 25 percent, with the biggest declines coming in the area of medical and surgical outpatient services. While the PVA figures represent a worst case scenario (under which a generous universal package is provided for non-VA users while VA is forced to survive with inadequate budget support), it is very likely that VA will experience some initial patient loss under health reform.

The staff of the Congressional Budget Office (CBO) developed an analysis of the expected profile of VA patients under health care reform and in a February 1994 "Re-estimate of H.R. 3600," concluded that, under health care reform, veteran demand for acute, non-psychiatric VA care will decrease as a result of veterans switching from VA to non-VA providers.

According to CBO, non-Category A veterans (non-service-connected, higher income veterans) and those with incomes below 150 percent of the poverty level are the most likely to leave the VA system. Under H.R. 3600, these veterans would face the same benefits and coinsurance requirements whether they chose a VA or non-VA plan and veterans below 150 percent of the poverty level would be eligible for essentially cost-free care under whichever plan they choose. Conversely, higher-income, non-Category A veterans would face similar cost-sharing obligations under either VA or non-VA plans.

CBO concluded that the VA would lose as much as 40 percent of non-service-connected Category A veterans with incomes below 150 percent of the poverty level. CBO based its conclusion on the assumption that many of these veterans currently using the VA

system do so because they do not have other health insurance alternatives, thereby making the VA their only health care option. Health care reform, however, could offer these low-income veterans full access to private health care, a choice, CBO believes, many would make. In addition, CBO assumed that VA would lose the small percentage of non-category A, higher-income veterans currently being served in VA facilities. According to CBO, under health care reform, these higher income veterans are not likely to give up their private health insurance to seek care in the VA. CBO projected that veterans "leaving" VA would result in an estimated workload reduction of 173,000 inpatient episodes and 7,000,000 outpatient visits in the first year.

CBO concluded that under health care reform, VA enrollees would comprise primarily non-service-connected veterans whose income is between 150 percent of the poverty level and the current Category A income threshold as well as service-connected veterans. These veterans are expected to continue to use the VA system because they would not be subject to the copayments and cost-sharing required under other non-VA plans. CBO viewed VA as a more attractive health care option for service-connected veterans because it would continue to offer them access to specialized services, such as treatment for spinal cord dysfunction, readjustment counseling, and extended mental health and rehabilitation services, that CBO anticipated would not likely to be part of the Comprehensive Benefits Package.

Overall, while significant numbers of veterans may "leave" the VA, the analyses on the impact of health reform do not suggest dramatic change in the health-care profile of those most likely to enroll for VA care. CBO, for example, does not expect VA to attract significant numbers of already insured higher income veterans. Such veterans and others, particularly those whose health profile would differ significantly from VA's current users, would generally have relatively little incentive to shift to a VA plan.

The Committee believes that since the demographic characteristics of both current and expected VA system users is unlikely to change, VA will have a considerably higher cost in providing for its patients' health care needs than would be expected for other groups under health care reform. While these patient demographics are not likely to change in the early stages of health care reform, the Committee believes VA must work to attract veterans outside of their current user profile. VA must attempt to attract a broader spectrum, including younger, healthier veterans. Testimony supporting this position was provided by Kenneth I. Shine, M.D. (President of the Institute of Medicine) at the Subcommittee on Hospitals and Health Care hearing on April 28, 1993 on the role of the Department in the national health care delivery system. At that hearing Dr. Shine stated, "if you are going to have a, quote, 'competitive' environment, you have to have a large enough population so that there are some of the low-cost [individuals] in the package. And that means being able to enroll a wide variety of veterans so that you, in fact, have a way of balancing those costs." Testimony from Earl Brown, M.D., (former Associate Chief Medical Director, DVA) at that hearing further supported this position, stating that in order for VA to compete under health reform "It is

critical that VA attract additional veterans so that you get a different mix of veterans, a 'normal' mix, so that the cost per patient per episode of care will be reduced."

Under health reform, health providers and insurers are not likely to target their marketing to the types of patients VA facilities now serve in large numbers. Veterans with multiple chronic illnesses often require extensive and intensive care with resultant high costs. The market incentives under health reform will not make such patients attractive enrollees to private sector plans. Graphic testimony on this subject was presented at the April 28, 1993 hearing by a VA Medical Center Director, who stated, "there has been very little competition for veteran patients by the private sector, and VA is the caregiver of choice of a large part of our veteran population . . . In health care reform, the competition will be fiercest for healthy 25 year olds who don't utilize much health care, yet the provider would presumably get the same fixed capitation payment as for an older and sicker patient."

Since it is unlikely that VA could markedly alter its patient mix during the early stages of national health reform, it is imperative that any reform efforts take these patient risk factors into consideration for funding purposes.

Funding must also be considered as it relates to the scope of benefits being provided this unique group of patients. Current VA eligibility rules limit the provision of preventive care, outpatient care for stable but chronic conditions, home health services, and durable medical equipment and prosthetics, for the most part, to only the most seriously disabled service-connected veterans. Expansion of a comprehensive benefits package to include these services to all poor and service-connected veterans is not reflected in the VA's historical resource base. While a benefits package for veterans which promotes sound principles of case management and which may allow veterans now being treated in VA hospitals to receive outpatient and home care may be less costly than current VA hospital care, it is critical to ensure that financing for the VA system is adequate to meet any additional cost associated with these expanded benefits while at the same time providing adequate risk adjustment for the elderly, poor and disabled veteran population VA now serves.

FLAWS IN TITLE VIII, H.R. 3600

H.R. 3600 aims to guarantee veterans care through the VA, but funding for the comprehensive benefits package would continue to depend heavily on the approprations process. That process has repeatedly fallen short of the system's needs. This proposed reliance on the annual appropriations process raises concerns.

During the last decade, dependence on appropriations has contributed largely to the chronic underfunding of the VA's health care system. As a result, the system has not kept pace with the need for infrastructure improvements and has had, to some degree, to ration care, particularly outpatient and long-term care. At many facilities veterans must endure long waiting lines and delays in scheduling clinic visits. For more than a decade, annual appropriation levels for VA health care have failed to keep pace with real medical inflation, and have forced belt-tightening at the veterans' expense. VA health care funding has been forced to compete

against other programs for an ever-diminishing pool of discretionary funds.

By its terms, H.R. 3600 entitles Americans to the comprehensive benefits package provided for in that bill. However, the guarantee afforded service-connected and low-income veterans who consider VA enrollment is only as reliable as the appropriations process on which they depend. H.R. 3600 provides the appearance of a guarantee to health care for those "core" veterans, but upon closer examination the foundation for this guarantee, an annual appropriation, provides no assurance that the funds provided will be sufficient to meet the health care needs of core veterans. Without such a guarantee, core veterans would face considerable uncertainty with regard to their health care benefits. By maintaining this considerable link to appropriations, H.R. 3600 fails in its attempt to provide core veterans choosing VA the same security afforded all other Americans, namely that they will have timely access to health care.

Among the legacies of the budget problems described above is a VA system infrastructure which has been permitted to decline at the expense of attempting to maintain direct service delivery. Those system problems—in the form of deferred maintenance and repair, mounting backlogs of needed replacement medical equipment, and long-deferred construction plans—place VA at a competitive disadvantage in relation to other health care institutions. While H.R. 3600, as introduced, made provision for a VA Health Investment Fund to help address such chronic problems and facilitate start-up of competitive health plans, the bill simply *authorized* such funding. As an authorization, the provision offered veterans no assurance that VA would receive these needed funds. Since such funding was intended to address significant problem areas within VA such as the need for replacement equipment, information systems, and outpatient clinic expansion, the bill's failure to assure such funding is a serious weakness.

In addition to these and other flaws in the funding of veterans' care under H.R. 3600, as introduced, the Committee has found the "eligibility reform" provided for in that bill to fall well short of the long-documented need for major revision. The need for VA eligibility reform has been well-documented. H.R. 3600 would introduce limited eligibility reform to the VA system through the required provision of services contained in the Comprehensive Benefits Package. However, the range of covered services is not as expansive in some respects as veterans may be receiving from the Department. Veterans needing VA services which are either not covered or not fully covered under health reform could, under H.R. 3600, confront the dilemma of being denied needed VA care because of now-anachronistic eligibility laws.

These and other substantial flaws in H.R. 3600 led the Committee to attempt to improve upon title VIII of H.R. 3600.

THE COMMITTEE AMENDMENT

The Committee amendment preserves the core of the veterans' provisions of the Health Security Act while strengthening those provisions to ensure that the goals of that legislation can be realized. In attempting to address the needs of veterans, the Administration intended the Health Security Act to make VA health plans

enrollment choices for all veterans, to enable them to furnish any enrollee the range of services covered under the bill, and to maintain cost-free care for low-income, service-connected, and other "core" veterans. By requiring VA to compete with other health plans for veteran enrollees, the bill injected a powerful incentive for improved service-delivery. As noted above, however, there were "holes" in the Administration's proposal, and the Committee amendment would repair them.

Plan Establishment and Organization.—The Committee amendment would retain those elements of H.R. 3600 which require the Secretary of Veterans Affairs to establish and operate health plans, and provide that Department health care facilities operate either as health plans or as providers within VA health plans. The Committee amendment recognizes that VA health plans may in many respects operate independently of one another. Nevertheless, VA's unique mission dictates that the Secretary promulgate and maintain some degree of uniformity in policy governing VA health plans insofar as those plans in both a real and symbolic dimension constitute links in a national network. That network must be organized to serve the veteran who, for example, enrolls in the Northeast yet requires care while wintering in the South. The Committee amendment implicitly rejects the notion that VA health plans would be governed by potentially inconsistent policies established in 50 different States. The Committee amendment explicitly directs the Secretary to prescribe regulations establishing standards for the operation of VA plans and facilities. The Secretary shall ensure that these standards comform to the maximum extent possible with requirements established for health plans in general.

Unlike private sector health care providers, the mission of the Veterans Health Administration is more expansive than simply providing the benefits and services which make up the comprehensive benefits package offered health plan enrollees. VA must continue to serve the needs of service disabled and other veterans, and provide benefits which are not fully covered under the Health Security Act, while maintaining its research, education, and contingency missions. Given VA's uniqueness as a national system as well as its broader statutory responsibilities, the Committee amendment recognizes that the Secretary must be free to frame standards which preserve the national character of the VA health care system, and that strike an appropriate balance with otherwise applicable requirements for health plans. Accordingly, the amendment proscribes States from imposing any standard or regulation on a VA health plan that would be inconsistent with applicable Federal statutory or regulatory requirements, or policies based on such requirements.

Given VA's importance to veterans, the amendment would protect veterans' rights to obtain health care through the VA by proscribing the imposition of standards or requirements on a VA health plan which are inconsistent with either the standards adopted by the Secretary or with applicable Federal law or regulation, or policies based on such law or regulation. Similarly, the amendment provides that a VA health plan may not be denied certification on the basis of a real or perceived conflict between the standards established by the Secretary and the rules, requirements

or standards adopted by a State or State-established entity—or between applicable Federal law or regulation and such State standards.

The amendment would further assure veterans' access to VA health care by requiring that any health insurance purchasing cooperative or similar entity that offers health insurance plans shall include any applicable VA health plan as an enrollment option for qualified individuals. The Committee amendment recognizes the likelihood that such purchasing cooperatives will be but one mechanism through which individuals may subscribe or enroll in health plans. The policy underlying the Committee amendment is that veterans should have every possible opportunity to enroll with a VA health plan. Recognizing that many employees would likely obtain health care coverage through their employers, the Committee amendment would provide that any obligation an employer may have under the Act with respect to employees, the offering of health plans and health plan options to such employees, and the payment of premiums, for example, shall be applicable to VA health plans.

The Committee intends that beneficiaries enrolled in VA health plans are ensured of at least the same medical services, access, and quality of care as members of other health plans. In that regard, VA must reassess and restructure its health care delivery system.

Among VA's challenges is the need to develop access to primary care services for its enrollees that meets community expectations for geographic accessibility and timeliness. Like other health plans, VA will have to create an expanded network of community-based providers. VA plans also will be faced with the challenge of creating access to services which the Department does not now provide such as obstetrical and pediatric care.

The Secretary may establish VA plans using an organizational structure that best meets the needs of plan operations and services to enrollees. The Secretary may take into consideration geographic referral paterns, demographic trends, Federal and applicable State requirements for health plan operations, and other factors in determining the most feasible configuration for VA plans. VA plan managers at all levels must have clearly defined operational responsibilities and be held accountable for financial, customer satisfaction, and medical care outcomes.

The Committee amendment regarding plan operations and establishment of VA plans are intended to provide VA with the flexibility to operate and manage a delivery system much different than it now has, one that ensures ready access to needed services and is responsive to its customers while maintaining high quality standards.

Enrollment.—The Committee amendment goes further than H.R. 3600, as introduced, in attempting to allow any veteran who is eligible for coverage under the Health Security Act to enroll with a VA health plan. Unlike H.R. 3600, the Committee amendment would assure that medicare-eligible veterans may enroll with a VA health plan. Also unlike H.R. 3600, which simply allows for the enrollment of CHAMPVA beneficiaries, the Committee amendment would exempt those individuals from the requirement to make a premium payment. The amendment would also require VA to offer

family members of enrollees the option of VA enrollment (rather than simply *authorizing* the Secretary to provide for such enrollment). The Committee's hearing record underscores the importance of VA plans' offering a family enrollment option (since *other* competing health plans would provide for family enrollment). Given the importance of making that option available to enrollees and seeming Departmental ambivalence about exercising the authority to provide for family enrollments, the Committee believed it necessary to assure that veterans and their families have that option.

Benefits.—The Committee amendment would require the Secretary to ensure that each VA health plan provides enrollees those services in the comprehensive benefit package of the Health Security Act. The amendment makes one exception in its proscription on abortion coverage other than when the limited circumstances specified in new section 1825(a)(1) and (2) of title 38, United States Code.

Like H.R. 3600, the amendment would also require VA to provide those services that are *not* covered under the comprehensive benefit package to veterans (whether enrolled in a VA plan or not) subject to provisions of chapter 17 of title 38, United States Code. It would go further and, as discussed more fully below, expand the access to care provided for in that chapter. In addition, it would require VA to maintain (in-house) its existing capacity to provide specialized treatment and rehabilitation to disabled veterans (such as treatment for spinal cord dysfunction, blindness, and post-traumatic stress disorder).

The Committee amendment, like H.R. 3600, would further authorize VA to offer supplemental health plans and would clarify that VA can offer such policies for services outside the basic benefits package, but cannot charge a veteran a premium for care it is obligated to furnish that veteran.

Cost-Sharing Obligations.—Under H.R. 3600, veterans who enroll in non-VA plans would without exception be subject to cost-sharing requirements if they elect to receive any services within the comprehensive benefits package from VA rather than through their own health plan. The notion of charging low-income or service-connected veterans for seeking care from VA is unprecedented. Yet the concept of enrollment is central to the establishment and maintenance of a viable health plan. To preserve a situation in which veterans might "opt out" of a VA plan, enroll elsewhere, and turn to VA only selectively and sporadically for isolated services is at odds with VA's serving veterans effectively as a provider of comprehensive care and as a cost-effective care manager. Veterans would have no incentive to enroll with VA if they could enroll in another plan and turn to VA only as a backup or episodic provider. Hearings before the Subcommittee on Hospitals and Health Care call into question the notion that VA could thrive or even survive were it to operate in such a manner. The Committee amendment thus maintains the concept of enrollment. But it would create an exception in authorizing VA to provide cost-free services to a veteran *not* enrolled in a VA plan if the veteran is seeking treatment for a service-connected disability that requires specialized treatment in which the VA has particular expertise (such as treatment of post-traumatic stress disorder). The amendment takes cog-

nizance of the fact that some veterans will inevitably opt out of the VA system, including service-connected veterans. The Committee is concerned that if substantial cost barriers stand in the way of those service-connected veterans availing themselves of some of the very specialized VA services which were developed to meet their unique needs, underutilization could force VA plan managers to eliminate unique, highly specialized services which may not be available in the community. The Committee amendment aims to avoid that result.

Under the Committee amendment, those "category A" veterans now eligible for any needed hospital care (primarily the service-connected and lower-income veterans), if enrolled in a VA health plan, would bear no cost for services covered under the comprehensive benefits package. Also, self-employed service-connected veterans would not be required to pay the employer share of the premiums. Veterans who have special eligibility for care of certain conditions in connection with possible exposure to toxic substances (based on amendments to title 38 passed by the House last session) and who enroll with a VA health plan would not be liable for copayments, deductibles or coinsurance payments for care of those covered conditions.

FINANCING

Under existing law, the VA health care system is funded out of general appropriations. Although VA collects from third party insurance carriers, those collections are, for the most part, returned to the Treasury. Under the Committee amendment, VA will gain access to additional funding sources.

Premiums.—Among new sources of funding will be premiums paid by, and on behalf of individuals and families that enroll in VA health plans. "Core" veterans, however, would not be liable to pay a premium to enroll in a VA health plan. (Core veterans include service-connected veterans, former POWs, World War I veterans and low income nonservice-connected veterans, those veterans to whom VA, under existing law, has an obligation to provide all needed hospital care.)

Under the amendment, employers who purchase insurance for their employees would pay premiums to VA on behalf of those employees who enroll in a VA plan. Enrollees who are not "core" veterans would pay that part of the premium not covered by the employer. Premiums would be paid by core veterans, however, for coverage of family members who elect to participate in a VA plan. VA would also receive premiums from individuals who, for whatever reason, are not covered by employer-purchased insurance. Certain low-income individuals would receive subsidies to cover that portion of premiums that would ordinarily be paid by employers, and may use the subsidies to purchase a health plan from VA. VA would retain premiums received from those who are not core veterans.

Individuals who are eligible for CHAMPVA benefits would not be liable to pay the individual premium portion if they enroll with VA.

Medicare Reimbursements.—Another new source of revenue for the VA system would be payments from the Department of Health

and Human Services (HHS) paid on behalf of certain veterans and dependents who are eligible for Medicare benefits.

H.R. 3600, as introduced, would require the Secretary of HHS to reimburse a VA health plan for services provided to higher-income veterans (those who under the bill are not subject to cost-sharing charges) in the same amounts and under the same terms and conditions that the Secretary of HHS reimburses other Medicare providers and Medicare HMOs. To that end, the introduced bill includes provisions that *deem* VA facilities to be Medicare providers, and VA plans to be Medicare HMO's, for any program administerd by the Secretary of Health and Human Services.

In recent testimony regarding VA's role under national health care reform, officials of GAO questioned the provisions granting VA "deemed Medicare provider status," and expressed a concern that that provision would free VA of complying with Federal requirements designed to protect enrollees against risk. In response to this concern, the Committee amendment provides appropriate safeguards by requiring the Secretary of Veterans Affairs annually to review all VA facilities and VA health plans and to certify to the Secretary of HHS a list of all VA facilities and plans which, with respect to those Medicare requirements which reasonably apply to a public facility, fully meet or exceed requirements identified in the amendment. Under this provision, VA facilities and plans must meet or exceed either Medicare requirements or VA's own requirements that achieve the same or similar purpose as Medicare requirements and which are not less stringent than the Medicare requirements.

These provisions are intended to preserve the autonomy of the veterans health care system while ensuring, at a minimum, the application of requirements and standards appropriate to the care of Medicare eligible beneficiaries through the system of their choice.

The Committee amendment also provides for payments to the VA under the Medicare program for care of Medicare eligible dependents of veterans as well as for Medicare eligible CHAMPVA beneficiaries. (It is noteworthy that existing law (38 USC 1713) provides that the CHAMPVA program is to furnish benefits subject to the same or similar limitations as CHAMPUS. As such, when CHAMPVA benficiaries reach age 65 and become eligible for Medicare, they lose eligibility for this VA administered benefit.) Dependents and CHAMPVA beneficiaries would be subject to any Medicare applicable copayments and deductibles.

Under the Committee amendment, Medicare payments received under these provisions, as well as collections for applicable copayments and deductibles for higher income veterans and dependents, are to be deposited and retained in the revolving fund established under the amendment. These revenues are not subject to offset of any kind. Provision of services to veteran's dependents and higher income veterans is not supported by any appropriation, and must be funded through the above-described collections.

Collections from Other Plans.—Under the Committee amendment, VA could collect funds from other health care plans when VA furnishes care covered by the comprehensive benefits package to enrollees of those other plans. The Committee intends that VA collect amounts permitted under the Act when an individual seeks

care from a plan other than the one in which he or she is enrolled. Additionally, the Committee amendment authorizes VA to contract with other plans to provide various services and to retain the proceeds of those contracts. For example, VA may contract with another plan to do all hip replacements as a provider to that plan's network.

Expanded Resource Sharing.—VA could also receive monies through use of the expanded contracting authority provided in new section 7343. Revenues generated through such contracting are to be retained and credited to the health plan fund.

The Committee amendment would expand existing authority for the VA to negotiate agreements with not only health care providers but with health insurers or any other entity or individual. The amendment further expands this authority to authorize VA to procure or to sell any health care resource, to include support services. The Committee contemplates that the Department would broadly construe this new authority. The authority would lend itself to some obvious applications such as an instance where a VA health plan might have a hospital laundry capability in a particular locality that exceeds its needs and then furnishes services to another provider for a negotiated reimbursement rate. But the Committee contemplates that the Department would look to this authority for still broader ends. VA may, for example, use this authority to enter into agreements with insurance carriers or individuals for agents or brokers to sell VA health plans. VA could also use this authority as a basis to obtain needed administrative or management-support services from other health plans, or use such authority as a foundation for a more far-reaching joint venture, under which VA could attempt to negotiate arrangements with an insurer or other entity to share risk with and manage care for VA plans as they start up. The Committee expects that VA, in undertaking planning efforts and developing business plans, will consider the use of this authority in its decision process and will foster further use of joint ventures with private sector entities.

Supplemental Policies and Cost Sharing Policies.—The Committee amendment would authorize VA to sell insurance policies covering benefits that are not included in the standard benefits package. (The policies sold to non-core veterans may include those services for which core veterans have mandatory eligibility under chapter 17.) In addition, the amendment would permit the Department to sell cost sharing policies which would cover the out-of-pocket expenses of purchasers for such things as copayments and deductibles. VA would retain the premiums paid for both of these types of policies.

Grants, Risk Adjustments, and Academic Health Centers.—VA health plans would have authority to obtain other new sources of funding provided for in the Act. For example, the Act may establish mechanisms to compensate health plans which have a disproportionate share of so-called "high risk" enrollees such as the elderly. The Committee intends that VA have access to any funds available to health plans to adjust for such a high risk population. Additionally, if the Act provides for grants to health plans to meet special needs, the Committee intends that VA health plans be eligible for those grants on the same basis as any other plan. Grants may be

made available, for example, to meet the needs of special populations in the community. Funds may also be available under the Act to meet the needs of academic health centers. The Committee intends that VA plans operating academic health centers be treated in the same manner as other similarly situated health plans or facilities. It is the Committee's intent that plans which include VA academic medical centers which qualify as teaching hospitals will be eligible for the case payment adjustments either from Medicare or from any newly established all-payer Academic Health Centers/Teaching Hospital Fund in recognition of the increased intensity, complexity and, therefore, cost, of caring for patients admitted to these hospitals. These plans would also be eligible to receive payments from any newly established all-payer Academic Health Centers/Teaching Hospital Fund.

Third party collections.—The Committee amendment would make explicit VA's authority under 38 USC section 1729 to recover under supplemental health insurance policies. (The amendment in would in no way diminish VA's existing authority to bill insurance carriers for the cost of care covered by any insurance policy. VA would also retain its ability to seek reimbursement under various workers compensation statutes, tort liability systems, and other 3rd party payers.)

The amendment would, however, provide for changing the *disposition* of monies recovered or collected under section 1729. Under existing law, amounts recovered or collected under section 1729, less the costs of collection, are to be deposited into a medical-care cost recovery fund maintained in the Treasury. Under new section 1834, *any* amount received by the Department by reason of care furnished by a VA health plan as well as premiums and other payments received by reason of enrollments; amounts received as third party reimbursements; and amounts received as reimbursements from other health plans for their enrollees is to be credited to the revolving fund described below.

The Committee intends that VA retain these third-party collections except for payments on behalf of core veterans.

Revolving Fund.—The Committee amendment would establish a revolving fund, to be known as the Department of Veterans Affairs Health Plan Fund, which would help the Department manage and account for the multiple funding streams contemplated under the amendment. The fund would be an account into which the Department would credit the various funds it would receive as described above, as well as payments the Department would receive from the Treasury Department under the guaranteed funding mechanism described below.

Each VA health plan and VA provider would have distinct and separate accounting of moneys within the revolving fund. The revolving fund would record and credit all revenues except those received through direct appropriations, and those credited to the transition fund. The Committee anticipates that the revolving fund would be segregated by payer source of revenue, as well as by organizational entity source of revenue. It would allow identification of locations, sources, and types of revenue to accommodate the breakdown of organizational payer source. The ability to identify individual sources of revenue would be useful in developing future mar-

keting strategies. Maintaining discrete revenue stream information would also be helpful in meeting external auditing requirements.

Amounts in the Veterans Affairs Health Plan Fund would be transferable from one distinct VA health plan to another distinct plan. Such a policy would allow VA to ensure that the services offered by the various VA plans are generally comparable, as well as to help ensure the viability of its health plans.

Amounts in the fund could be used to cover both direct and indirect costs of providing covered benefits under the comprehensive benefits package. Indirect costs include costs of administering and operating the health plans. For example, it is anticipated that legal services will be provided in support of the various plans offered by the General Counsel of VA. The cost of such legal services are to be considered a part of the cost of administering the plan and may be charged to the funds allocated for the plan.

Federal funding.—VA will continue to need appropriated funds to meet the nation's obligation to its veterans, obligations which are far broader than those encompassed in a mandate to provide health plan enrollees with covered benefits. Accordingly, the Department should continue to receive general appropriations. Nevertheless the obligations inherent in maintaining the Government's commitment to service-connected, low-income, and other core veterans, are such that a new funding mechanism is needed to ensure that the Department is financially able to provide all needed covered services to all core veterans who enroll with VA.

Funding for Treatment of Core Veterans.—Under H.R. 3600, funding for the treatment of service-connected and low-income "core" veterans who enroll with VA would continue to be dependent upon annual appropriations (to cover the premium costs of unemployed veterans, medicare-eligibles, and veterans employed by corporate alliances, as well as to cover "lost" coinsurance and deductible charges which other non-VA plans would receive but which will not be borne by "core" veterans). While H.R. 3600 specifies that each eligible individual is *entitled* to the comprehensive benefits package through the applicable health plan in which that person enrolls, dependence on the appropriations process renders that "entitlement" very vulnerable. This reliance on appropriated funds raises the threat that future budgetary constraints could undermine the "guarantee" that should be inherent in enrolling in a health plan.

The nature of the beneficiary group itself as well as the long-standing policy of providing these deserving veterans cost-free care heightens the challenge of adequately funding VA for care of "core" veterans. As discussed above, the Committee anticipates that VA's "core" veteran enrollees will as a group be disproportionately older, sicker, and far more costly to care for than most health plans' enrollee groups. Providing these veterans cost-free care poses an additional financial pressure. A recent study by the Office of Technology Assessment, "Benefit Design: Patient Cost Sharing" concludes (and thus affirms earlier studies) that utilization of services by patients is significantly increased in the absence of cost share requirements.

The Committee amendment addresses these concerns by establishing a funding mechanism that takes account both of VA's obli-

gation to these veterans and of the potentially high cost of providing them care.

The Committee amendment would provide that each quarter, the Secretary of the Treasury must pay to VA an amount that will cover the cost of providing care to all core veterans that VA projects will be enrolled in VA health plans at the beginning of the quarter. The amount would be determined by multiplying the number of projected core veterans by a capitated amount to cover the cost of caring for each veteran.

In the process of projecting the number of core veterans expected to be enrolled in any given quarter, the Department must adjust for incorrect projections in previous quarters. Thus, VA must consider the difference between the projected number of core veterans enrolled in previous quarters, and the number that were actually enrolled. Such adjustments will ensure that these veterans are accurately counted over an extended period by making up for any over- or under-estimating.

For the first five years of VA plan operation, the capitated amount VA will receive from the Treasury Department each quarter will be based on an initial capitation rate which will be adjusted annually using the medical care consumer price index calculated by the Bureau of Labor Statistics.

The Committee amendment would allow the capitated enrollment amount for each enrolled veteran to grow at an annual rate equal to the medical consumer price index in the belief that it is the most appropriate adjustment factor. In the Committee's view, in a managed competition arena, VA costs will rise or fall for the same reasons that non-Federal health care providers' costs rise or fall. VA should not, therefore, be tied to a different index. It should also be noted that a principal goal of the Health Security Act is to rein in runaway health care costs. It aims to shrink the difference in growth rates between health care costs and those of other sectors of the economy. To the extent the bill succeeds, the differences between the medical CPI and the indices currently used to adjust for growth in VA medical costs should gradually disappear. It is noteworthy, finally, that VA spending has long been constrained and since its base funding is already at an artificially low level, it would be unreasonable to place VA into a competitive setting in which its cost-adjustment index also fails to account for costs it is incurring.

The method for determining the initial capitation rate is generally set forth in the Committee amendment. However, the Committee has provided that the specific methodology must be established by VA in consultation with the Comptroller General. To help ensure that this is a collaborative effort, the amendment provides that if the Comptroller General disagrees with the methodology proposed by the Secretary, then the Comptroller General is to notify the Committees on Veterans' Affairs of the House and Senate of that fact, and any appropriate legislative action can be considered.

Under the Committee's proposal, the initial capitation rate will be established by first determining the most recent annual full cost VA has incurred in providing services in the comprehensive benefits package to core veterans who received them. That cost must be

based on the most recent cost data available to VA, and then must be adjusted for inflation using the medical care consumer price index. The Committee intends that the Comptroller General's role be one of assisting VA in determining the full annual cost, and the data that are used in making that determination. Once the full annual cost is determined, it should be divided by the number of core veterans to whom VA provided the services. This will determine the capitated amount.

The Committee proposal further provides that in determining VA's full annual cost of caring for core veterans, the Department must include the amount appropriated for 1994 for medical and prosthetic research in the Veterans Health Administration. The purpose of that requirement is to ensure that VA continues to receive funding to meet its research mission at levels at least equal to levels in fiscal year 1994. Additional research funding would require general appropriations.

The Committee expects that as the reformed national health system becomes more established, VA health plans will operate with costs that are somewhat similar to the costs experienced by other health plans. Thus, the Committee amendment would provide for a change in the method for determining the capitated amount after a five-year period. The amendment provides for, and the Committee expects, that the new method would be to base the capitated rate on the average premium paid by individuals in non-VA health plans that have demographic characteristics and patient risk characteristics similar to VA plans. However, the Committee is cognizant of the fact that VA's experience may indicate a need to use an alternative method for capitation. Accordingly, the amendment provides that after three fiscal years of using the initial capitated amount, the Secretary should submit to the Committees on Veterans Affairs of the Congress, a report on actions needed to change the methodology to that described above. Alternatively, the report could suggest some other methodology that could be used without a reduction in the quality of care.

VA Payments to the Treasury.—While the funding mechanism described above aims to ensure that VA has sufficient funding to care for core veterans, account must be taken of the fact that VA would also receive employer premium payments on behalf of the same veterans for whom it is receiving capitated payments. To permit retention of premiums in that instance would effectively be to countenance dual payment. The Committee amendment provides, accordingly, that VA credit to the Treasury all premium payments received by or on behalf of core veterans.

Under the Committee amendment, VA would, however, retain all premium payments, Medicare payments, and all cost shares paid on behalf of non-core veterans, and for the families of enrollees. VA must retain those monies to pay for the care of those enrollees.

The Committee is aware that VA, like other health plans, will adapt its premiums to family structure. For example, it is expected that VA may receive one premium amount for providing the comprehensive package to a family consisting of two parents, and children. A different premium would apply to providing coverage to a single parent family, and still a third premium for providing the benefits to an individual. The amount of the premium payment

that must be transferred to the Treasury on behalf of core veterans will not be the premium cost for an individual. It would be the difference between the cost of a two-parent family policy, and the cost of a single parent family policy. To illustrate, if VA were to offer a family health plan covering two adults and two children, it might charge a premium of $4,000. For a single parent with two children, the premiuim might be $3,500. Finally, for a single adult, the premium could be $2,000. In the case of a core veteran who is married and has two children, the premium amount that would be submitted to the Treasury from the revolving fund would reflect the difference in cost between the premium for two adults and two children and premium for a single adult and two children, or $500. The Committee intends for VA to retain the premium amount necessary to cover the costs of the care of the veteran's dependents.

Transition Fund.—Under virtually any national health care reform, the VA health care system will face a transition. The Committee amendment envisions that VA will undergo a profound change from a totally Federally-funded health care system providing care to many veterans who have no other source of care to one which competes with other health plans for veterans and their family members who have other choices. The Committee contemplates that, to be able to provide more competitive services, VA will need to make major capital investments as well as incur substantial start-up costs associated with establishing health plans. A special transition fund is needed to provide for the start-up of health plans and infrastructure improvements associated with this transition. The fund is available to meet diverse needs including construction; acquisition of equipment and supplies; analysis and reconfiguration of systems; improvements in patient amenities; contract care; leasing; marketing research and services; advertising; and evaluation services.

H.R. 3600, as introduced, authorized appropriations of $3.3 billion over three years for an investment fund for use in connection with VA health plans. The Administration has identified that vehicle as a means to help the Department fund the establishment of health plans and meet related infrastructure needs to enable VA to more effectively compete with other health plans. But, as an authorization, the Committee is of the view that there is no assurance that these "investment" funds would be provided. And without substantial startup funds VA facilities would be at a substantial competitive disadvantage in relation to other health plans.

To overcome these problems and achieve the Administration's goals for an investment fund, the Committee amendment would *direct* that such funding be provided to VA. It would increase the level of such funding, however, by $250 million/year. That figure is based on the Administration's Fiscal Year 1995 budget for VA which slashed funding for major medical construction and conditioned the fate of some $250 million of construction projects on funding through the investment fund. The investment fund was not conceived as a substitute for the major construction appropriation.

To enable the Committee to assess the impact and adequacy of funding provided through the transition fund, the Committee amendment would require the Secretary to provide Congress a report no later than March 1, 1997. The report would include a dis-

cussion of the adequacy of amounts in the Transition Fund for the operation of VA health plans; the quality of care provided by VA health plans; the ability of such plans to attract patients; and the need (if any) for additional transition funds beyond fiscal year 1997.

General Appropriations.—It is the Committee's belief that with national health care reform, no veteran should be left with fewer health care benefits then those for which the veteran is now eligible. Accordingly, the Committee proposal provides that any veteran, whether enrolled or not, may continue to receive benefits now authorized under chapter 17, of title 38, United States Code, even if the benefit is *not* provided in the comprehensive benefit package. If a benefit is included in the comprehensive package, the veteran will, of course, receive it through enrollment. The continued "chapter 17" benefits will be funded with general appropriations.

A wide array of supplemental benefits are not fully covered or included under the comprehensive package. These include long term mental health and substance abuse treatment programs. Both intermediate care and long-term care, including the State home grant and per diem and VA domiciliary programs, would continue to depend on appropriated funds. VA would also continue to provide more extensive dental care than might be included in the standard package. (Other special disability programs are discussed more fully below.)

General appropriations will also be needed to permit VA to fulfill its missions in the areas of education, research, and as a backup support system for the Department of Defense. The Committee expects that VA will obtain funds to meet research costs partially through the guaranteed funding mechanism which requires consideration of research costs in the determination of the capitated amount VA will receive from the Treasury Department. In including such costs within the base from which guaranteed funding is provided, the Committee has taken cognizance of the unique clinical aspects of VA research as a critical component of the care provided to veterans. The Committee amendment thus aims to provide a measure of stability to the VA research program by identifying VA research costs as an element of the cost of providing health care to veterans.

However the Committee does not envision that such funding will provide more than a base of support, and anticipates that much of VA's research effort, including funding for the salaries for clinical investigators, will continue to come from appropriations.

The Committee is cognizant that VA operates many of its medical centers as teaching hospitals or academic health centers. Collectively, these hospitals conduct 10 percent of all medical resident training in this country. Given the broad social purpose served by this aspect of the VA health care system, the Committee intends that VA funds for graduate medical education will continue to be a part of the VA appropriation, funding those residents training in VA facilities.

The Committee continues to believe VA must be prepared to play a backup role in support of the Department of Defense in times of national security emergency. Fortunately the nation did not have to call on VA for medical support of DOD at the time of the Persian

Gulf War, but having VA in a position to provide the support if it were needed, was invaluable. Appropriations will continue to be needed to support that VA mission. VA has also played a substantial a role in assisting during times of natural disaster. The ability of VA to fulfill that crucial role must also be funded through general appropriations.

Single payer plans.—Health reform proposals before the Congress have provided States an option of establishing single payer systems. Under single payer systems, the State or other State designated entity serves as the health "insurer" or payer for State residents. Under such a system, the State would negotiate or establish fee schedules with providers, perform managed care functions such as arranging for specialty services like organ transplants, and manage revenues.

The Committee believes that veterans and their dependents residing in areas which adopt single payer systems must have comparable access to choice of care through the VA health system as do veterans who reside in other parts of the country.

Under the Committee amendment, depending on the structure established by states electing single payer systems, VA could either operate health plans or have its facilities in those states serve as community providers to veterans and their dependents. In the event that health plans are not established in single payer areas, VA facilities would be authorized to provide all services included in the standard benefits package to all veterans, their dependents, and CHAMPVA beneficiaries, and to receive reimbursements for those services from the State payer system to the same extent as any other provider would for the same services. The VA would be able to retain these reimbursements in its revolving fund. "Core" veterans from single payer states obtaining care from VA facilities would be exempt from any aplicable cost share payments to the VA.

Financial Risk.—H.R. 3600 recognizes that there are significant financial risks for all health care providers in guaranteeing to provide covered services to a group of health plan enrollees. Several measures to reduce these risks and to ensure that plans are able to meet obligations to enrollees are included in the President's proposal. Among these requirements dealing with financial risk-management are required contributions by plans into State managed guarantee funds, requirements for the maintenance of reserve funds, and requirements for the purchase of reinsurance. State-managed guarantee funds are to be used to subsidize the cost of care for enrollees in plans that are failing and unable to provide services to plan members. Maintenance of reserve funds ensures that plans will have sufficient operating capital on hand to cover costs at any time. Standard industry practice today is one month's operating costs maintained in reserve. The purchase of reinsurance protects plans against catastrophic and unforseen events such as costs associated with major natural disasters and epidemics.

In the Committee's view, there is little basis for imposing on VA an array of fiscal requirements designed with private health plans in mind. At the same time, the Committee recognizes the importance of ensuring that VA health plans are established and operated in such a manner as to minimize to the extent practicable the

risk of financial insolvency or instability. The Committee amendment thus requires the VA, in establishing and operating health plans, to consult with the Comptroller General on, and to take appropriate steps to ensure, the solvency and stability of VA health plans and their contractors.

While the Committee amendment relieves VA from specific financial requirements imposed on other health plans, the Committee recognizes that practices such as the maintenance of reserves and the purchase of reinsurance are sound business practices. In that regard, the Committee amendment authorizes the Secretary to purchase reinsurance from commercial sources to protect VA health plans from financial risk should the VA, in consultation with the Comptoller General, determine that to be prudent. The Committee expects that the VA and Comptroller General likewise will consider the development of guidelines for VA plans relating to the maintainenance of some operating reserves as well as other standard health industry practices.

Administrative flexibility

The Committee amendment reflects a recognition that under national health reform, health plans would essentially compete for enrollees. While private sector providers, health maintenance organizations, and other entities have long operated in a competitive mode, the VA health care system has necessarily functioned entirely diffently. Hearings have lent considerable support to the view that, despite inexperience in functioning as a health plan, VA has unique strengths that could make it an attractive enrollment option and that can be effectively marketed to those eligible to enroll. Nevertheless, as a Federal agency, the VA would continue to be subject to a vast body of law and regulation which would impede and frustrate its capacity to function effectively as an agile, decisive player in the health reform marketplace.

VA's need to develop quickly a managed-care delivery network, however, makes critical a more flexible procurement policy than current law can accommodate. Given the importance of making care easily accessible to enrollees, VA will not be able to rely on its existing, often widely dispersed health care facilities alone to deliver primary care service. Provider-services contracting will, therefore, be crucial to VA's efforts to deliver care to the veteran as conveniently as possible. VA will have to enter into hundreds, if not thousands, of contracts. It will be necessary for VA plans throughout the nation to establish medical care networks with private physicians and hospitals, as well as with other ancillary medical care providers. Additionally, VA plans may have to enter into contracts for administrative support with managed care companies, financial intermediaries, insurers, benefits administrators, utilization review companies, consultants and computer information system companies, as well as contracts for clerical and maintenance help.

A particular dilemma for VA is that many of the entities with which VA health plans would be competing under health care reform already have established provider networks and an administrative support system. While its likely competitors are poised to enter the health-reform marketplace, VA itself remains locked in a

statutory and regulatory framework that does not even permit it to ready itself fully for this competitive challenge. While current laws and regulations pertaining to competition and procurement policy may be suitable for traditional Government contracting, they are too cumbersome and time consuming to meet VA's need to bring an effective medical care network on line relatively quickly.

Many of the providers with whom VA would seek to contract are physician practice groups which are unfamiliar with the rules of Government contracting. Doing business with the Federal government is widely known to be complex and difficult to understand by those who are unaccustomed to the Federal government's many requirements. Preparing a proposal or bid under the current system is also time consuming and costly to these providers. Given both competition in the marketplace among those entities establishing provider networks and the inherent concerns about contracting with the Federal government, many physician practice groups are likely to be resistant to entering into contracts with the VA.

To address the challenges facing VA in contracting for needed services, subsection (a) of section 7343 would authorize a VA health plan or the director of a VA health care facility that is operating as or within a VA health plan to furnish or obtain health care resources without regard to any law or regulation pertaining to competitive procedures, acquisition procedures or policies (other than contract dispute settlement procedures), or bid protests.

In light of the substantial challenges facing VA under health reform and the formidable impediments confronting VA under existing law, the provision would exempt VA from all laws and regulations that could interfere with its ability to enter into contracts for health care resources. VA would only be subject to the Contract Disputes Act, 41 United States Code 601 et seq., as it provides an efficient, low cost means of resolving contract disputes. VA would be exempt from all other statutes, regulations, or policies affecting Federal government contracting. For example, this subsection would exempt VA from *Chapter 4 of The Federal Property and Administrative Services Act*, 41 USC 251–260, and *Chapter 7 of The Office of Federal Procurement Policy Act*, 41 USC 401 et seq., when acquiring health care resources. These Acts establish uniform procurement regulations, including the requirement for Truth in Negotiations, Federal Acquisition Regulations (FAR), Veterans Affairs Acquisitions Regulations (VAAR), and other requirements for procuring agencies. Section 7343 would exempt VA from the specific requirements of such acts as the Procurement Integrity Act, 41 USC 423; the Competition in Contracting Act of 1984, 41 U.S.C. 253; Cost Accounting Standards 41 USC 422, Examination of Records by Comptroller General 41 USC 254(c), Submission of Cost And Pricing Data, 41 USC 254(d). And, with respect to procurement policy, the preference for contracting-out of Government services set forth in *OMB Circular A–76* would be replaced by reliance on the sound business judgment to determine when a plan would benefit from using employee/in-house resources, rather than contracting out for them. Exempting VA contracting (relating to the establishment or operation of VA health plans) from these statutes and regulations is intended to streamline the contracting process so as to free contracting officials from procedures which do not apply

to most health plans with which VA would likely compete. For example, current laws and regulations pertaining to Federal procurements allow vendors to protest agency procurements. While under protest, these procurements are usually suspended, delaying them for many months. For a VA plan to operate under such a policy could severely impede its ability to establish a provider network and effectively serve potential enrollees. Under section 7343, VA health plans would also be exempt from Protests to Court of Federal Claims (Pre-award protests), 28 USC 1491 Protests to Comptroller General (Pre-award, post-award disputes on solicitation, award decisions), 31 USC 3551 et seq.; Protests to General Services Board of Contract Appeals (GSBCA) (Pre-award, post award disputes on solicitation, award decisions of Automated Data Processing (ADP) contracts), 40 USC 759: Protests to District Courts (Pre or post award), 5 USC 702, 28 USC 1346(a)(2).

Reflecting the enormity of VA's challenge in establishing and operating health plans, the Committee amendment confers broad authority to obtain any health-care resources. Such resources include automatic data processing equipment. Consistent with the goals of the Committee amendment, VA health plans would be exempt under section 7343 from the *Brooks Act*, 40 USC 759, and Federal Information Resource Management Regulations (FIRMR), 41 CFR 2.001 and Parts 201–233.

Under current law, the General Services Administration has paramount authority for leasing and disposing of Federal property, 40 USC 471–544. To the extent that a VA health plan is leasing health care resources, section 7343 would supersede that authority. That exemption is necessary to ensure that the discretion of a VA health plan to determine to lease is not hindered.

Other procurement laws dictate the selection of vendors on factors other than cost and value. The policies reflected in such laws are at odds with the aims of health reform and conformity with such laws would be inconsistent with the aims of ensuring that VA health plans can operate as viable competitors in the health care marketplace. In furtherance of those goals, section 7343 would free VA health plans of any obligation to meet these mandates.

Given the importance of being able to contract effectively for services either in establishing or operating a health plan, the Committee has unquestionably provided the Department considerable latitude. That latitude is not unlimited, however, and, by way of clarifying those limits, the Committee amendment includes a provision to ensure that contracting under section 7343 be subject to a procurement policy, to be developed by the Secretary, which should be consistent with broad Federal procurement policy (though not necessarily subject to Federal *procedures*) on nondiscrimination, equal opportunity, business integrity, and safeguarding against potential for fraud and abuse.

Subsection (a)(2) of Section 7344 would authorize VA to procure commercially available items costing less than $100,000 without regard to any laws or regulations pertaining to competition, mandatory sources of supply, or bid protests, if such items are necessary to provide health care services. This provision would put VA on a more equal footing with competing health plans, which are free to purchase goods and services based on business judgment and cur-

rent market conditions, and would give VA the ability to purchase items necessary for patient care efficiently, cost effectively, and as needed. To simplify, streamline, and expedite the process for acquiring off-the-shelf items, the Committee amendment would exempt these procurements from an array of laws and regulations. For example, such procurements would be exempt from the provisions related to competition set forth in *Chapter 4 of The Federal Property and Administrative Services Act*, 41 USC 251–260, and *Chapter 7 Of The Office of Federal Procurement Policy Act*, 41 USC 401 et seq., the *Competition and Contracting Act of 1984*, 41 USC 253; the *Brooks Act*, 40 USC 759; any other Federal statute pertaining to competition, and the resultant procurement regulations, e.g., FAR, VAAR, FIRMR, and other requirements.

In addition, the sources from which VA may procure commercially available supplies would no longer be limited by the following: *GSA Federal Supply Schedules*, 41 CFR 101–126; Public Utilities Act, 40 USC 481; *Excess Personal Property* (priority supply source), 40 USC 483; Government Printing Office, 44 USC 501; GSA Stores Stock (priority source of supply), 40 USC 481; GSA Motorpools (priority source of vehicles), 40 USC 491; Federal Prison Industries (priority source of supply), 18 USC 4124; Wagner-O'Day Act (priority source of supply from nonprofit organizations of blind or handicapped), 41 USC 46 et seq.; Preference for U.S. Flag Vessels, 46 USC App 1241(b); *Buy America Act* (preference for supplies produced in the U.S.), 41 USC 10a–10d; and *Trade Agreements Act of 1979* (certain countries' products may be treated as if domestic in origin), 19 USC 2501 et seq.

As in the case of procurement of health care resources discussed in section 7343, and for the same reasons applicable to those procurements, issues raised by vendors during the procurement of commercial items would not be subject to resolution through any of the following adjudicative processes: Protests to Court of Federal Claims (Pre-award protests), 28 USC 1491, Protests to Comptroller General (Pre-award, post-award disputes on solicitation, award decisions), 31 USC 3551 et seq.; Protests to GSBCA (Pre-award, Post-award disputes on solicitation, award decisions of ADP contracts),40 USC 759; Protests to District Courts (Pre or Post Award), 5 USC 702; 28 USC 1346(a)(2).

It is important to note, in connection with the specific citations above, that the above-referenced statutes and procurement policies are cited simply as illustrations of provisions from which VA plans would be exempt under the Committee amendment and do not represent an exhaustive listing.

In that regard, section 7344(a)(2) would also authorize VA, based on a finding that it is necessary or cost-effective to provide health care services in the context of health-reform, to enter into contracts without regard to section 8110(c) of title 38, United States Code. This statute authorizes the contracting out of activities at a VA health care facility only on the basis of a determination that the activity is not a direct patient care activity or incident to patient care and the conduct of a study comparing the costs of contracting with continued performance by VA employees. Section 7344(a)(2)(B) would, in appropriate circumstances, authorize VA to bypass this lengthy process, and, like other health plans make judgments

which weigh the choice of in-house and contractor service solely on the basis of business judgment.

Under health reform, VA would be at a very distinct competitive disadvantage not only under Federal contract law but under applicable Federal personnel law. Thus, the Committee amendment at subsection (b) of section 7344 would authorize the VA Secretary to establish alternative personnel systems or procedures for all personnel assigned to VA facilities operating as or with health plans whenever the Secretary considers such action necessary in order to carry out the terms of that Act.

This subsection would provide the VA Secretary with broad, flexible authority to facilitate VA's establishing and operating health plans. The Health Security Act would place VA in competition with other health plans both for veteran enrollees and for employees. Section 7344(b) would enable VA to design effective and competitive alternative personnel systems and procedures. These alternative personnel systems could cover all classes of VA employees involved in health care delivery: title 5, title 38, hybrids, wage-grade and Senior Executive Service. The intent and purpose of this provision is to fully enable VA to establish an effective, efficient health plan and to compete effectively and equally with other health care providers and systems. To remain effective and competitive in meeting the health care needs of veterans, VA must be able to attract veterans as enrollees in VA plans.

Under this authority, VA could create new personnel systems or procedures for its health care delivery employees, separate and distinct from existing title 5 and title 38 personnel systems, either in whole or in part, depending on VA needs in operating health plans. These alternative personnel systems or procedures could include:

—flexible compensation, pay and benefits systems;

—recruitment incentives and other tools (e.g., payment of education expenses, bonuses, relocation costs);

—relief from title 5 and title 38 personnel restrictions (e.g., appointment, qualification, promotion, advancement, premium pay and disciplinary authorities);

—alternative dispute resolution methods;

—performance management systems;

—disciplinary and adverse action procedures;

—organizational structures and strategic workforce planning; and

—employee development programs.

In authorizing VA to establish new personnel systems or procedures, the Committee emphasizes that it is not proposing to confer unfettered authority. The Committee amendment signals its concern that certain fundamental principles remain key elements of any personnel policy. For example, the Committee amendment expressly addresses the subject of veterans preference, reflecting the expectation that the Department would continue to apply that principle. The amendment also identifies a number of policies which must be elements of whatever personnel system are established. The delineation of those policies is intended to ensure that fundamental, broadly accepted personnel principles are core elements of any VA systems. At the same time, the Committee amendment seeks to preserve flexibility regarding the specific design of such

system or the specific procedures under which it would operate. The enumeration of elements of a personnel system in the listing in section 7344(b)(2) should not be construed as exhaustive. For example, the Committee does not by its silence on the subject signal any intention that VA dispense with a retirement system. The Committee's intention is that the VA Secretary may elect to continue coverage under the Federal employee retirement systems, or may establish separate retirement systems more closely matching those of the private sector.

The Committee amendment does not attempt to set a specific limit on the outer boundaries of this new personnel authority. There is an expectation that certain laws would continue in effect, including laws guaranteeing collective bargaining rights and standards of ethical conduct. Also, as Federal employees, affected VA employees would continue to be covered by on-the-job injury compensation and unemployment compensation, benefits generally available to all employees, whether private sector or government. Although Congress intends that the new alternative personnel systems would continue existing collective bargaining relationships and procedures, the decision of the Secretary to establish alternative systems and procedures, and to what extent, is not itself subject to bargaining.

Eligibility Reform.—H.R. 3600 would revise VA eligibility law generally by extending to core veterans who enroll with a VA health plan those services covered under the comprehensive benefits package. But enactment of the Health Security Act would otherwise leave intact the complex statutory limits on access to VA care codified in chapter 17 of title 38, United States Code. Thus, long-criticized eligibility rules which, for example, make it easier to obtain costly hospital care than to obtain ambulatory care would continue to govern VA provision of services which are not covered as basic benefits.

The Committee amendment would go still further to reform VA eligibility laws. These changes are intended to improve VA health delivery (by basing access to care on clinical rather than legalistic criteria), to provide a full continuum of care for those with the highest priority to such services, and to establish additional incentives for veterans to enroll with VA health plans. They would also eliminate impediments in existing law to receipt of needed prosthetic devices.

The Committee amendment would make the following eligibility law changes:

—mandate nursing home care for veterans who are 50 percent or more service-connected disabled and for service-connected veterans needing such care for their service-connected conditions;

—mandate, in the case of "core" veterans who enroll with VA health plans, that VA provide any needed outpatient medical services which are not covered under the comprehensive benefits package (to include services such as mental health care for which duration of treatment is limited under the benefits package); and

—*eliminate* provisions of current law which *limit* outpatient treatment for many veterans to circumstances where such care is required to "obviate a need for hospitalization" or to follow-up inpatient care.

Preservation of specialized treatment capacities.—Pursuant to its statutory mandate to provide complete medical and hospital services for the care and treatment of veterans, VA provides a very broad array of health care and rehabilitative services. Among these, are services targeted to the specialized treatment and rehabilitative needs of veterans suffering from spinal cord dysfunction, blindness, and mental illness. These services go beyond the level of care required under the comprehensive benefits package proposed in the Health Security Act, and the Committee has indicated its strong support for the preservation of treatment capacities in these areas.

VA furnishes these "additional" chapter 17 benefits solely through appropriated funds. The high cost of delivering many of these services and the variability of resource allocation has historically created problems. At this juncture, however, the Committee is particularly concerned that VA officials or individual medical center administrators could conclude that because these programs and services are funded by a "discretionary" appropriation, that they are vested with discretion to provide or withhold funding support for these programs and services. The Committee amendment makes it clear that such a conclusion has no basis in law. In fact, the reporting requirement recognizes the need for the Committee to have more information regarding these programs in order to provide adequate fiscal protection.

These programs were designed and established to address a paramount mission of the Department of Veterans Affairs—to serve the specialized needs of the disabled veteran population. In many instances, such as with care for spinal cord dysfunction, VA programs and services constitute a unique regional or even national resource. For example, in the acute care arena, VA provides a full spectrum of SCI services beginning with treatment of the newly injured patient through a comprehensive rehabilitative program designed to meet the individual needs of those with SCI conditions. Post rehabilitation, VA offers periodic sustaining care to treat any complication of SCI. It should be noted that the long-term rehabilitation and sustaining care provided through VA's 22 SCI centers and specialized clinical operations have no known parallel component in the private sector. In providing these services, VA has established itself as a national leader in medical education and research in the field of spinal cord medicine and rehabilitation. In many respects, the same can be said for VA blind rehabilitation centers and programs to treat post-traumatic stress disorder. The Committee amendment thus underscores a concern that these assets should be maintained, at least at the current level of services, with a commitment to quality care. The Committee would in fact encourage the Veterans Health Administration, as it expands its outpatient and primary care base, to expand the availability of these specialized programs in those new service areas.

The Committee amendment would require the Department to submit an annual report to the Committees describing its actions to carry out the requirements of new section 1822(c) relating to preservation of VA's specialized treatment capacities. The Committee notes that the statutory requirement is written in general terms, but its application to VA's pertinent specialized programs

will dictate the scope and substance of that reporting. As the requirement relates to the VA SCI program, for example, the Committee anticipates that this report will address a number of specific areas. The requirement that the Department maintain its capacity to provide for specialized treatment and rehabilitation of disabled veterans necessarily means that the Secretary must look beyond the walls of an SCI unit, for example, and must take account of all the services which support that unit, be they driver training, social services, plastic surgery, or general medicine. To maintain this multi-faceted array of services requires, first, that VA identify what would comprise a full continuum of patient treatment services. In order to identify the myriad of services necessary to provide quality care in specialty areas, the Committee encourages the Veterans Health Administration to examine the body of work published in the field of practice parameters by recognized medical professional groups such as the American Medical Association. The Committee believes that VA should weigh the use of practice parameters for specialized services with an eye to determining whether use of such guidelines can improve the quality of care, encourage consistency in the definition of specialized services, and assure appropriate utilization of those services. In addition, having a clear definition of what constitutes this type of care could facilitate preservation of those services.

In employing the concept of practice parameters, the Committee envisions *strategies* for patient management developed to assist physicians and other health care providers in clinical and therapeutic decisionmaking. Practice parameters may address issues ranging from general aspects of medical care to management of specific clinical conditions. They also may identify a range of interventions such as diagnostic, therapeutic, and or preventive management of specific interventions which may be appropriate.

The Committee understands that practice parameters are highly variable in their content, format, degree of specificity, and method of development. Accordingly, the Committee views practice parameters as guidelines, and not standards against which to measure or evaluate performance or effectiveness in service-delivery. In that connection, diversity in practice is acceptable when based on local resources, patient population, and scientific uncertainty. While stressing that practice parameters are simply guidelines, the Committee nevertheless emphasizes the importance of the manner in which they are developed. It is important that parameters be developed in conjunction with physician and health-care professional organizations. Such interplay in their development is important to achieve a multi-disciplinary approach to quality care and patient satisfaction. The development of parameters must be supported by relevant scientific literature. In that regard, the Committee encourages VA to consult with and review guidelines and practices developed by the Agency for Health Care Policy and Research. It is also important that those participating in the development of parameters should be actively involved in the pertinent clinical practice areas relevant to developing the guidelines in question.

Thus, the Committee anticipates that the VA will include in its report to Congress, a discussion of practice parameters related to the delivery of specialized services. When parameters are developed

they should be published or described in the report. The report should also identify all services which constitute and support the provision of care for those veterans in need of specialized care, and identify the full continuum of care for veterans with specialized needs. The report should also include information identifying the strength of scientific evidence behind the suggested parameters and the degree and origin of the expert judgment involved, and projections of health and outcomes associated with using the parameters. Effective parameters should be valid, reliable, reproducible, clinically applicable, clinically flexible, and clear. Credibility and accountability are the underpinnings of good practice parameters, and should be based on scientific and clinical evidence.

This report should also identify the patient populations (with sufficient precision as to identify the aggregate treatment and rehabilitative needs of those patients) requiring specialized services. The Committee would expect that an annual reporting which links practice parameters with data on patient needs would enable the Department to estimate the resource requirements (which should be identified in the report) associated with maintaining (and expanding as necessary) the specialized capacity for veterans in need of these services.

Section-By-Section Analysis

Subtitle B of title VIII would provide the authority for the Department of Veterans Affairs (VA) to participate in health care reform.

Section 8101(a) would insert a new chapter in title 38, United States Code. Chapter 18 would be titled, "Eligibility and Benefits Under Enrollment-Based System."

SUBCHAPTER I—GENERAL

Section 1801 of title 38, United States Code would provide the definitions for purposes of the new chapter.

SUBCHAPTER II—ENROLLMENT

Section 1811 would provide for the enrollment of each veteran determined eligible within the meaning of section 1001 of the Heath Security Act, including a veteran who is a medicare-eligible individual, with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the VA shall enroll with a VA health plan.

Section 1812 would provide for the enrollment of specified CHAMPVA eligibles: (1) the surviving spouse or child of a veteran who died as a result of a service-connected disability or at the time of death was a permanently and totally service-connected disabled veteran, and (2) the surviving spouse or child of a person who died in the line of duty in the active military, naval, or air service.

Section 1813(a) would provide for the veteran to enroll family in the VA health plan. If the enrollee chooses to enroll family members, all such family members must be so enrolled.

Section 1813(b) would require enrolled family members to pay premiums, deductibles, copayments, and coinsurance as required under the Health Security Act.

Section 1813(c) would provide for "grandfathering" any family member who is enrolled in a VA plan in the event of the death of that veteran.

Section 1813(d) would provide that the members of the family of an enrollee are those defined as "family" in section 1011(b) of the Health Security Act.

SUBCHAPTER III—BENEFITS

Section 1821 would require the Secretary of Veterans Affairs to ensure that each enrollee in a VA health plan receives the items and services in the comprehensive benefit package under the Health Security Act.

Section 1822(a) would require VA to provide care and services that are not included in the comprehensive benefit package as authorized in Chapter 17 of title 38.

Section 1822(b) would require VA to provide the care and services authorized in Chapter 17 of title 38, United States Code, in any VA facility, to any veteran who is not eligible, in accordance with section 1001 of the Health Security Act, to enroll in a VA health plan.

Section 1822(c) would require VA to maintain its specialized treatment and rehabilitative capabilities within distinct programs or facilities that are accessible and dedicated to the specialized needs of certain veterans. The Secretary is to ensure that the overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, as of the date of enactment of Chapter 18. The Secretary would not be precluded from expanding the number or type of facilities or programs that provide treatment and rehabilitation services for the specialized needs of such veterans, including specialized services on an outpatient basis.

Section 1822(d) would require the Secretary to submit to the Committees on Veterans Affairs of the House and Senate by March 1 annually, a report describing the actions taken to carry out subsection (c) during the preceding fiscal year. Each report is to include the numbers of veterans for which specialized services were provided, the cost of providing those services, and a description of the alternatives available in the private sector.

Section 1823 would authorize a VA health plan to offer supplemental health benefits packages and supplemental cost sharing policies consistent with the requirements of part 2 of subtitle E of title I of the Health Security Act. VA is not to offer coverage to a veteran for care which it already has an obligation to provide.

Section 1824(a) would require a VA health plan to be reimbursed, when it provides items and services in the comprehensive benefit package to a veteran who is enrolled in a health plan not operated by the VA, for care provided.

Section 1824(b) would exempt a veteran from otherwise applicable cost-sharing obligations arising under new section 1824(a) in the case of treatment for a service-connected disability that requires a specialized treatment capacity for which the VA has particular expertise.

Section 1825(a) would prohibit a VA health plan from providing or arranging to provide an abortion except in the case of rape, incest, or life endangerment.

Section 1825(b) would clarify that subsection (a) is not to be construed to remove or diminish coverage other than for abortions.

Section 1825(c) would provide that the National Health Board may not expand the comprehensive benefit package to include any abortion that is excluded under subsection 1825(a).

SUBCHAPTER IV—FINANCIAL MATTERS

Section 1831(a) would exempt veterans described in subsection (b), who are enrolled in a VA health plan, from providing a cost-share charge of any kind, whether a premium, copayment, deductible, coinsurance charge, or other charge, for items and services in the comprehensive benefit package that are provided within a VA plan network. The Secretary would be required to make arrangements as necessary with the appropriate health insurance purchasing cooperative or with appropriate Federal, State, or other officials to carry out the subsection.

Section 1831(b) would identify those veterans exempt from providing a cost-share charge as any veteran: (1) with a service-connected disability; (2) whose discharge or release from active military, naval or air service was for a disability incurred or aggravated in the line of duty; (3) who is in receipt of, or who, but for a suspension pursuant to section 1151 of title 38 would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section; (4) who is a former prisoner of war; (5) of the Mexican border period or World War I; and (6) who is unable to defray the expenses of necessary care as determined under section 1722(a) of title 38, United States Code.

Section 1831(c)(1) would authorize the Secretary to charge premiums and establish copayments, deductibles, and coinsurance amounts to all veterans except those identified in section 1831(b).

Section 1831(c)(2) would provide that VA is not to collect premium payments from CHAMPVA eligibles.

Section 1831(c)(3) would provide that VA is not to charge a copayment, deductible or other coinsurance in the case of care for any disease covered under title 38, United States Code, section 1710(e)(1), applicable to enrolled veterans for treatment in connection with exposure to certain herbicides, ionizing radiation, toxic substances or environmental hazards.

Section 1831(d) would provide for the establishment of a premium rate and the rates for deductibles and copayments for each VA health plan based on rules applicable to all health plans operating in the geographic area in which it is operating.

Section 1831(e) would waive the collection of any employer premium payment, owed under section 6126 or 6111 of the Health Security Act, from a self-employed service-connected veteran.

Section 1831(f) would provide that the obligations of employers with respect to a VA health plan and employees enrolled in such plan shall be the same as those that apply to other health plans and the employer's other employees.

Section 1832(a) would require the Department of Health and Human Services (HHS) to pay the VA facility or VA health plan for care provided to Medicare-eligible individuals other than "core" veterans as described in section 1832(b). Payment shall be in the same amount as provided to any other Medicare provider or Medicare HMO.

Section 1832(b)(1) would provide that a VA health care facility could be deemed a Medicare provider and a VA health plan could be deemed a Medicare HMO when appropriate certification, pursuant to section 1832(b)(2) has been provided to the Secretary of HHS.

Section 1832(b)(2) would require the Secretary of Veterans Affairs to certify annually to the Secretary of HHS, with respect to Medicare requirements that are applicable to any public facility, a list of all VA health facilities and VA health plans that, either fully meet or exceed Medicare requirements, or fully comply with the Secretary's requirements intended to achieve the same or similar purposes as Medicare requirements, and are no less stringent than Medicare requirements.

Section 1832(c) would authorize the VA to collect from a medicare-eligible enrollee any deductible or copayment that is not covered by the Medicare program when care is provided.

Section 1832(d) would provide the definitions of terms associated with the Medicare program.

Section 1833 would authorize the VA health plan in the case of an individual provided care or services through a VA health plan who has coverage under specified supplemental health insurance policies or plans to recover the costs of certain care and services from third parties when services are provided for non-service connected conditions.

Section 1834(a) would establish in the Treasury a Department of Veterans Affairs Health Plan Fund.

Section 1834(b) would provide for the revolving fund to be credited with any amount received by VA (1) by reason of a VA health plan's furnishing care, (2) by reason of individual enrollments, (3) received as third party reimbursements, and (4) received as reimbursements from other health plans.

Section 1834(c) would authorize any amounts deposited to the revolving fund from premiums on behalf of "core" veterans to be covered into the General Fund of the Treasury.

Section 1834(d) would authorize expenditures from the revolving fund for all expenses, both direct and indirect, related to the delivery of comprehensive benefit package and any supplemental benefits package.

Section 1835(a) would require the Secretary of Treasury to deposit in the VA Health Plan Fund on the first day of each fiscal year quarter an amount, not otherwise appropriated, and certified by the Secretary of Veterans Affairs, during which the Secretary operates a VA health plan.

Section 1835(b) would require the Secretary of Veterans Affairs to certify, no later than 30 days before the beginning of each fiscal year quarter, the amount determined for that quarter.

Section 1835(c) would provide for the determination of the amount to be certified by projecting the number of VA enrollees as

of the beginning of that quarter and the capitated enrollment amount for that fiscal year determined under subsection (d). Adjustments in future certifications are provided for when there are differences between the actual number of veterans enrolled for a fiscal year quarter, the projected number used in the certification for that quarter, and any information the Secretary finds would produce a more accurate capitated enrollment amount.

Section 1835(d)(1) would provide that the initial capitated enrollment amount shall be determined as the amount equal to (A) the annual full cost (as defined in OMB Circular A-25, issued on July 8, 1993) that has been incurred by the Department in providing those services specified to be included in the comprehensive benefit package, based upon the most recent cost data available at that time, adjusted for inflation to the date of the determination based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, divided by (B) the total number of veterans who received those services.

Section 1835(d)(2) would require the Secretary to include in the total annual cost the amount appropriated for fiscal year 1994 for the medical and prosthetic research functions of the Veterans Health Administration.

Section 1835(d)(3) would direct the Secretary to develop the methodology for determining the initial capitated enrollment in consultation with the Comptroller General of the U.S. Should the Comptroller General disagree with the Secretary's proposed methodology, the Comptroller General is to promptly notify the Committees on Veterans Affairs of the House and Senate. The determination of that amount shall be made not later than June 1, 1995.

Section 1835(d)(4) would provide that the initial capitated enrollment amount, adjusted annually for inflation, shall apply for the first five fiscal years during which the Secretary operates a VA health plan.

Section 1835(d)(5) would require the Secretary of Veterans Affairs, not later than the end of the third fiscal year, to submit a report to the Committees on Veterans Affairs of the House and Senate. The report would indicate what actions would be necessary for the Department to change the annual capitated enrollment amount by the end of the fifth fiscal year to an amount (A) determined by reference to the average premium that would be payable under the Health Security Act for individuals enrolled in health plans other than VA health plans which have enrollment populations with disproportionate numbers of persons with similar demographic and patient-risk characteristics to the population of VA enrollees or (B) to amounts determined using some other methodology.

Section 8101(b) of the Health Security Act would amend Chapter 17 of title 38, United States Code, by inserting a new section 1705, titled, "Facilities not operating within health plans; veterans not eligible to enroll in health plans." Section 1705 would provide that the provisions of Chapter 17 of title 38, United States Code are to apply to (1) any facility not operating as a health plan and not located in a State (or portion of a State) that under the Health Security Act is a single payer area and (2) any facility, whether a certified health plan or not, in the case of a veteran who is not an eli-

gible individual within the meaning of section 1001 of the Health Security Act.

Section 8102 of the Act would amend Chapter 73 of title 38, United States Code by redesignating subchapter IV as subchapter V and inserting after subchapter III a new subchapter IV, titled "Participation as Part of National Health Care Reform."

Section 7341(a) of title 38, United States Code would authorize the Secretary to organize and prescribe standards for health plans and operate VA facilities as or within health plans under the Health Security Act.

Section 7341(b) would provide that within a geographic area or region, VA health care facilities may operate as a single health plan encompassing all VA facilities within that area or region or may be organized to operate as several health plans.

Section 7341(c) would provide that within a geographic area or region other than a State that under the Health Security Act is a single payer area, any health insurance purchasing cooperative, health alliance, or similar entity that offers health insurance plans shall offer as an option to eligible individuals any VA health plan that is operating in that area or region.

Section 7341(d) would provide that any health insurance program that is provided for Federal employees shall include VA health plans as enrollment options for eligible individuals. Premiums would be paid to a VA health plan.

Section 7341(e)(1) would require the Secretary, after consultation with the Comptroller General, to take appropriate steps to ensure the financial solvency and stability of each VA health plan and of contractors and subcontractors providing services.

Section 7341(e)(2) would authorize the Secretary to purchase from commercial sources insurance to insure the Department against the financial risks involved in the operation of any VA health plan.

Section 7341(e)(3) would provide that notwithstanding any other laws, there will be no requirements applicable to a VA health plan with respect to the maintenance of a reserve fund, requirements to reinsure, or payments into any other financial integrity fund other than as established by the Secretary under section 7341(e)(1).

Section 7341(f)(1) would prohibit a State from imposing any standard or requirement on a VA health plan that is inconsistent with this section, with standards adopted by the Secretary under section 7341(a) or with other Federal laws.

Section 7341(f)(2) would prohibit States from denying certification of a VA health plan under the Health Security Act on the basis of a conflict between a rule of a State and this section, VA regulations or other Federal laws regarding the operation of a VA health plan.

Section 7342(a) would authorize VA facilities to serve as providers to eligibles, in accordance with chapter 18, title 38, United States Code, in those States operating as a single payer system. VA facilities may provide those individuals any covered service in the comprehensive benefit package.

Section 7342(b) would authorize reimbursement to the VA, in single payer areas, for care provided on the same basis as any other provider furnishing the same services in that area.

Section 7342(c) would provide, in single payer areas, for the exemption of charges, copays, deductibles and coinsurance for individuals identified in section 1831(b) and 1831(c)(3).

Section 7343(a)(1) would authorize certain officials to enter into agreements with health care plans with insurers, health care providers, and with any entity or individual to furnish or obtain any health-care resource.

Section 7343(a)(2) would designate those individuals authorized to enter into agreements as the head of a VA health plan; the director of a VA health care facility that is operating as or within a VA health plan; and the Director of a VA facility that is operating in a State that is a single payer area.

Section 7343(a)(3) would provide the authority to enter into agreements for health-care resources without regard to competitive procedures, acquisition procedures or policies (other than contract dispute settlement procedures), or bid protests.

Section 7343(a)(4) would define the term "health-care resource" as that provided in section 8152 of title 38, United States Code.

Section 7343(b) would require the Secretary to ensure procurements for health-care resources are carried out consistent with (1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse, and (2) the goal of a streamlined process for the acquisition of health-care resources.

Section 7343(c) would authorize the proceeds from health-care resource agreements to be credited to the Health Plan Fund and to the facility that furnished the resource.

Section 7344(a)(1) would authorize the Secretary to carry out administrative reorganizations in the VA without regard to the provisions of title 38, United States Code, section 510(b).

Section 7344(a)(2) would authorize the Secretary, when it is cost-effective or necessary to provide health care services in a timely manner to enter into contracts for procurement of commercially available items under $100,000 without regard to any provision of law or regulation requiring competitive procedures; mandating or giving priority to any source of supply; or pertaining to protests; and to enter into contracts without regard to title 38, United States Code, section 8110(c), for the performance of services previously performed by employees of the VA.

Section 7344(b)(1) would authorize the Secretary to establish alternative personnel systems or procedures for personnel at facilities operating as or with health plans or for personnel at facilities operating in a State as a single payer area. The alternative personnel system or procedures shall provide for preference eligibles.

Section 7344(b)(2) would require the alternative personnel system or procedures to include the following components: appointments, promotions, and assignment of employees or applicants would be based on merit and fitness; an equal employment opportunity program; a compensation system used to set rates of pay competitive with rates paid by health-care providers other than the VA, taking into consideration the difficulty, responsibility, and qualification requirements of work performed; a formal performance appraisal system; a system to address unacceptable conduct

and performance by employees; and a formal policy regarding the accrual and use of sick and annual leave.

Section 7344(c) would authorize the Secretary to carry out appropriate promotion, advertising, and marketing activities to inform individuals of the availability of VA facilities operating as or within health plans.

Section 7345(a) would establish the Veterans Health Care Transition Fund and direct the Secretary of Treasury to credit the fund with $1.25 billion for fiscal year 1995; $850 million for fiscal year 1996; and $1.95 billion for fiscal year 1997.

Section 7345(b) would authorize the use of the Health Care Transition Fund for start-up of VA health plans, without fiscal year limitations, to include consultant services, equipment, marketing, and construction costs.

Section 7345(c) would require the Secretary of Veterans Affairs to submit to Congress no later than March 1, 1997, a report concerning the operation of the VA's health care system in preparing for and operating under national health care reform for fiscal years 1995 and 1996. The report is to include a discussion of the adequacy of the amount in the Health Care Transition Fund for the operation of VA's health plans; the quality of care provided by the plans; the ability to attract patients; and the need for additional funds following fiscal year 1997.

Section 7346 would authorize the Secretary to apply for and accept grants or other sources of funding intended to meet the needs of special populations.

Section 8103(a) of the Health Security Act would amend section 1710(a)(1) of title 38, United States Code to require the Secretary to furnish needed nursing home care to any veteran for a service-connected disability or to a veteran who has a service-connected disability rated at 50 percent or more for any disability.

Section 8103(b) would amend section 1712(a)(1) of title 38, United States Code, to require the Secretary to furnish needed outpatient care for any "core" veteran, enrolled in a VA health plan, for any disability to the extent that care and treatment of that disability is not included within the comprehensive benefit package.

Section 8103(c) would amend section 1712(a) of title 38, United States Code, to authorize outpatient treatment on the basis of clinical need; to strike paragraph (5) of section 1712(a) which sets forth more limited conditions under which treatment may be authorized; and to make conforming changes.

Section 8103(d) would make conforming amendments in chapter 17 of title 38, United States Code to reflect the amendment striking paragraph (5) of section 1712(a).

Section 8104 would extend authority, through September 30, 1996, to provide hospital, nursing home, and outpatient care to Vietnam veterans exposed to a herbicide agent, for any disease for which the National Academy of Sciences has found (or subsequently finds) either some evidence of, or insufficient evidence to permit a conclusion as to, an association between occurrence of the diseases in humans and exposure to a herbicide; and to veterans exposed to radiation, for any disease for which the Secretary determines there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radi-

ation. Veterans who have received VA care under special eligibility provisions are "grandfathered."

Section 8105 would extend authority, through October 1, 1998, to provide priority inpatient and outpatient care for veterans exposed to environmental hazards while serving on active duty in the theater of operations during the Persian Gulf War for certain disabilities which become manifest before October 1, 1996.

Section 8106(a) would require the Secretary of Veterans Affairs to submit to Congress a report on the desirability and feasibility of waiving any requirement for cost-sharing in providing medical care to a family member of a Persian Gulf veteran, who may have been exposed to environmental hazards, and who is enrolled in a VA health plan.

Section 8106(b) would describe the medical care provided to a family member as treatment for any disease or disability occurring in that family member which the Secretary finds may be related to the service of the veteran in the Southwest Asia theater of operations during the Persian Gulf War.

Section 8106(c) would require the Secretary, in preparing the report under this section, to consider relevant studies by the specified departments and agencies of the government and private health care providers.

Section 8106(d) would require the report to the Congress be submitted no later than 60 days after the date of the enactment of this Act.

Section 8107(a) would require the Secretary of Veterans Affairs, in each of fiscal years 1995 through 1997, to study the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals eligible for enrollment in a VA health plan.

Section 8107(b) would require a report be submitted to the Committees on Veterans Affairs of the House and Senate, 120 days after enactment, and annually thereafter through 1998, which includes descriptions of telemedicine applications benefiting veterans.

Section 8107(c) would require the study referenced in 8107(a) to be carried out in consultation with the Secretary of HHS, Secretary of DoD, Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

Section 8108 would provide that the amendments made by subtitle B of title VIII of the Act are to take effect with respect to those veterans described in new section 1831(b) of title 38, United States Code on October 1, 1995, and would require the Secretary of Veterans Affairs to take such steps as necessary to implement those provisions with respect to those veterans by that date.

Oversight Findings

No oversight findings have been submitted to the Committee by the Committee on Government Operations.

Congressional Budget Office Cost Estimate

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 29, 1994.

Hon. G.V. MONTGOMERY,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for an amendment in the nature of a substitute to subtitle B of title VIII of H.R. 3600, the Health Security Act. Subtitle B contains the provisions of the bill that relate solely to the Department of Veterans Affairs. The amendment was ordered reported by the House Committee on Veterans' Affairs on July 21, 1994.

The enclosed estimate shows the effects of the Committee amendments relative to H.R. 3600, as introduced. If included in other proposals, the effects of the amendments would differ.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act.

If you wish further details on this estimate, we will be pleased to provide them.

ROBERT D. REISCHAUER,
Director.

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: An amendment in the nature of a substitute to subtitle B of title VIII of H.R. 3600.

2. Bill title: The Health Security Act.

3. Bill status: As ordered reported by the House Committee on Veterans' Affairs on July 21, 1994.

4. Bill purpose: To coordinate the provision of health care to veterans and their families by the Department of Veterans Affairs (VA) with the system for health care financing that would be established by the Health Security Act.

5. Estimated cost to the Federal Government: The following table shows the effects of the Committee amendments relative to H.R. 3600, as introduced. If included in other proposals, the effects of the amendments would differ.

HOUSE VETERANS' AFFAIRS COMMITTEE AMENDMENTS TO H.R.3600, THE HEALTH SECURITY ACT

(By fiscal year, outlays in millions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
DIRECT SPENDING										
Increase Capitation Level by Medical CPI	0	60	360	1,420	1,970	2,590	3,240	3,950	4,700	5,510
Switch Spending for Medical Research to Mandatory	0	40	110	300	310	320	330	340	360	370
Veterans Health Care Transition Fund	1,250	850	1,950	0	0	0	0	0	0	0
Total Direct Spending Amendments	1,250	950	2,420	1,710	2,280	2,910	3,570	4,290	5,060	5,880
AUTHORIZATION										
Expand Outpatient and Nursing Home Care Eligibility	0	0	10	20	20	20	30	30	30	30
Switch Spending for Medical Research to Mandatory	0	-40	-110	-300	-310	-320	-330	-340	-360	-370
Veterans Health Care Investment Fund	-1,000	-600	-1,700	0	0	0	0	0	0	0
Total Authorization Amendments	-1,000	-640	-1,810	-270	-280	-290	-310	-320	-330	-340
Total Impact, Veterans' Affairs Committee Amendments	250	320	620	1,440	1,990	2,610	3,260	3,980	4,730	5,540

Detail may not add to total due to rounding.

Note: This estimate shows the effects of the Committee amendments relative to H.R. 3600, as introduced. If included in other proposals, the effects of the amendments would differ.

Basis of Estimate

INCREASE CAPITATION LEVEL BY MEDICAL CPI. The estimate of H.R. 3600, as introduced, assumed that VA spending to provide the comprehensive benefits package to enrolled veterans would increase for inflation at the rate currently used to project discretionary spending in the baseline for the Medical Care account. The Committee amendments would provide for a permanent indefinite appropriation to finance the cost of basic benefits based on a formula that would increase the average cost per veteran by the medical care component of the consumer price index (CPI). Because the projected rate of increase under the medical CPI is about 250 basis points higher than that currently projected for the Medical Care account, the effect of this change would be an increase in cost that compounds over time.

SWITCH SPENDING FOR MEDICAL RESEARCH TO MANDATORY. The Committee also proposes to include spending now financed through the Medical and Prosthetic Research account in the permanent indefinite appropriation mentioned above. As a result, the currently projected spending for this activity is shown as an increase in direct spending and an equal decrease in authorized appropriations.

VETERANS HEALTH CARE TRANSITION FUND. H.R. 3600, as introduced, contains an authorization of appropriations in 1995, 1996, and 1997 for a newly created Veterans Health Care Investment Fund. A total of $3.3 billion would be authorized over the three-year period. The Committee amendments would strike the authorization of this discretionary account and would replace it with an appropriation of $4.05 billion over the same period to a fund entitled the Veterans Health Care Transition Fund. Because the amendment would provide the spending authority for these funds, this spending would be mandatory.

EXPAND OUTPATIENT AND NURSING HOME CARE ELIGIBILITY. Under H.R. 3600, certain restrictions would apply to the coverage of outpatient and nursing home care under the comprehensive benefits package. The Committee amendments would provide veterans enrolled in VA health care plans with all medically necessary outpatient care and would provide unlimited VA nursing home care for the care of a veteran's service-connected disability or for the care of any condition of a veteran who has a service-connected disability rated at least 50 percent disabling.

The expanded eligibility to outpatient care would apply primarily to psychiatric and substance abuse treatment, because these are limited to 30 visits per year under the comprehensive benefits package. The cost of this expansion is estimated at around $20 million a year. The increased nursing home coverage is not expected to have a significant budgetary impact, because virtually all veterans in the two affected categories who require nursing home care receive that care under current law.

Because the expansion of outpatient and nursing home care provided by the Committee amendments would be in excess of the benefits included in the comprehensive package, the added cost would be funded from VA's continuing discretionary appropriation for medical care.

MEDICARE REIMBURSEMENT FOR DEPENDENTS OF VETERANS. Finally, the Veterans' Committee proposes to authorize VA to bill

Medicare for care provided to dependents of veterans who have family enrollment in VA plans. The net federal budgetary impact of this authority would be negligible.

VA officials have stated that dependents of veterans enrolling in VA plans would not be treated in VA facilities. Rather, their care in private and community facilities would be insured by VA in the same manner as other qualifying health plans. For those dependents who are Medicare-eligible, private providers would bill Medicare directly, and VA would not be involved. Because the dependents would be eligible for Medicare under current law, total Medicare expenditures should not be affected.

Should VA change its position and allow dependents to use VA facilities, the cost of this provision would still not be significant. To the extent that Medicare-eligible dependents use VA facilities, an increase in mandatory spending would be incurred for the cost of their care. This increase, however, would be offset by the collection of copayments and deductibles from beneficiaries and a reduction in Medicare reimbursements to non-federal providers.

6. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The spending increases that would result from these amendments would have the following pay-as-you-go impact, in addition to that resulting from H.R. 3600 as introduced.

[By fiscal year, in millions of dollars]

	1995	1996	1997	1998
Change in outlays	1,250	950	2,420	1,710
Change in receipts	Not applicable			

7. Estimated cost to State and local governments: None.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: K.W. Shepherd.

11. Estimate Approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

Inflationary Impact Statement

The enactment of the reported bill would have no inflationary impact.

Changes in Existing Law Made by the Bill, as Reported

Pursuant to the terms of the referral of the bill to the Committee, the Committee adopted amendments to subtitle B of title VIII.

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the portions of the bill to which amendments were adopted by the Committee, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

* * * * * * *

PART II—GENERAL BENEFITS

PART II—GENERAL BENEFITS

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

SUBCHAPTER I—GENERAL

§ 1701. Definitions

For the purposes of this chapter—

(1) * * *

* * * * * * *

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 1710 and 1712 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive health services, and [(except under the conditions described in section 1712(a)(5)(A) of this title)], wheelchairs, artificial limbs, truss-

es, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(I) * * *

(II) in the discretion of the Secretary, of the non-service-connected disability of a veteran eligible for treatment under section 1712[(a)(5)(B)] of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

* * * * * * *

§ 1703. Contracts for hospital care and medical services in non-Department facilities

(a) When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary, as authorized in section 1710 or 1712 of this title, may contract with non-Department facilities in order to furnish any of the following:

(1) * * *

(2) Medical services for the treatment of any disability of—

(A) a veteran described in section 1712(a)(1)(B) of this title;

(B) a veteran described in paragraph (2), (3), or (4) of section 1712(a) of this title, [for a purpose described in section 1712(a)(5)(B) of this title] *to complete treatment incident to hospital, nursing home, or domiciliary care that has been provided by the Department*; or

* * * * * * *

§ 1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans

The provisions of this chapter shall apply with respect to the furnishing of care and services—

(1) by any facility of the Department that (A) is not operating as or within a health plan certified as a health plan under the Health Security Act, and (B) is not located in a State (or portion of a State) that under the Health Security Act is a single payer area; and

(2) by any facility of the Department (whether or not operating as or within a health plan certified as a health plan under the Health Security Act) in the case of a veteran who is not an eligible individual with the meaning of section 1001 of the Health Security Act.

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

(a)(1) The Secretary shall furnish hospital care, and may furnish nursing home care *(or, in the case of a veteran described in subparagraph (A) or (D) below, shall furnish nursing home care)*, which the Secretary determines is needed—

(A) * * *

* * * * * * *

[(e)(1)(A) Subject to paragraphs (2) and (3) of this subsection, a veteran—

[(i) who served on active duty in the Republic of Vietnam during the Vietnam era, and

[(ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used in connection with military purposes during such era,

is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

[(B) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds was exposed while serving on active duty to ionizing radiation from the detonation of a nuclear device in connection with such veteran's participation in the test of such a device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning on September 11, 1945, and ending on July 1, 1946, is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

[(C) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

[(2) Hospital and nursing home care may not be provided under subsection (a)(1)(G) of this section with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in subparagraph (A), (B), or (C) of paragraph (1) of this subsection.

[(3) Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(1)(G) of this section after June 30, 1994, or, in the case of care for a veteran described in paragraph (1)(C), after December 31, 1994.]

(e)(1)(A) Subject to paragraph (2), a herbicide-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for any disease specified in subparagraph (B).

(B) The diseases referred to in subparagraph (A) are those for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined—

(i) that there is sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent;

(ii) that there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but such evidence is limited in nature; or

(iii) that available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

(C) A radiation-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for—

(i) any disease listed in section 1112(c)(2) of this title; and

(ii) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

(2) Hospital and nursing home care may not be provided under or by virtue of paragraph (1)(A) after September 30, 1996.

(3) For purposes of this subsection and section 1712 of this title—

(A) the term "herbicide-exposed veteran" means a veteran (i) who served on active duty in the Republic of Vietnam during the Vietnam era, and (ii) who the Secretary finds may have been exposed during such service to a herbicide agent;

(B) the term "herbicide agent" has the meaning given that term in section 1116(a)(4) of this title; and

(C) the term "radiation-exposed veteran" has the meaning given that term in section 1112(c)(4) of this title.

* * * * * * *

§ 1712. Eligibility for outpatient services

(a)(1) Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—

(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service);

(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more;

(C) to any veteran for a disability for which the veteran is in receipt of compensation under section 1151 of this title or for which the veteran would be entitled to compensation under that section but for a suspension pursuant to that section (but in the case of such a suspension, such medical services may be

furnished only to the extent that such person's continuing eligibility for medical services is provided for in the judgment or settlement described in that section); [and]

(D) during the period before [December 31, 1994, for any disability] *October 1, 1998, for any disability which becomes manifest before October 1, 1996,* in the case of a veteran who served on active duty in the Southwest Asia theater of operations during the Persian Gulf War and who the Secretary finds may have been exposed to a toxic substance or environmental hazard during such service, notwithstanding that there is insufficient medical evidence to conclude that the disability may be associated with such exposure[.]*;*

(E) to any veteran described in section 1831(b) of this title who is enrolled under section 1811 of this title and the Health Security Act with a VA health plan (as defined in section 1801 of this title), for any disability to the extent that care and treatment of that disability is not included within the comprehensive benefit package (as defined in section 1801 of this title);

(F) during the period before October 1, 1996, to any herbicide-exposed veteran for any disease listed in section 1710(e)(1)(B) of this title; and

(G) to any radiation-exposed veteran for any disease covered under section 1710(e)(1)(C) of this title.

(2) [The Secretary shall furnish on an ambulatory or outpatient basis medical services for a purpose described in paragraph (5) of this subsection—] *Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—*

(A) to any veteran who has a service-connected disability rated at 30 percent or 40 percent; and

(B) to any veteran who is eligible for hospital care under section 1710(a) of this title and whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension under section 1521(d) of this title.

* * * * * * *

(4) Subject to subsection (f) of this section, the Secretary may furnish on an ambulatory or outpatient basis [medical services for a purpose described in paragraph (5) of this subsection]*, to the extent that facilities are available, such medical services as the Secretary determines are needed* to any veteran who is eligible for hospital care under section 1710 of this title and who is not otherwise eligible for such services under this subsection.

[(5)(A) Medical services for a purpose described in this paragraph are medical services reasonably necessary in preparation for hospital admission or to obviate the need of hospital admission. In the case of a veteran described in paragraph (4) of this subsection, services to obviate the need of hospital admission may be furnished only to the extent that facilities are available.

[(B) In the case of a veteran who has been furnished hospital care, nursing home care, or domiciliary care, medical services for a purpose described in this paragraph include medical services rea-

sonably necessary to complete treatment incident to such care. Such medical services may not be provided for a period in excess of 12 months after discharge from such care. However, the Secretary may authorize a longer period in any case if the Secretary finds that a longer period is required by reason of the disability being treated.

[(6)] *(5)* In addition to furnishing medical services under this subsection through Department facilities, the Secretary may furnish such services in accordance with section 1503 of this title.

[(7)] *(6)* Medical services may not be furnished under paragraph (1)(D) with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in that paragraph.

* * * * * * *

(i) The Secretary shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, unless compelling medical reasons require that such care be provided more expeditiously:

(1) * * *

* * * * * * *

(3) To a veteran [(A)] who is a former prisoner of war[, or (B) who is eligible for hospital care under section 1710(e) of this title].

* * * * * * *

§ 1712A. Eligibility for readjustment counseling and related mental health services

(a) * * *

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a physician or psychologist employed by the Department (or, in areas where no such physician or psychologist is available, a physician or psychologist carrying out such function under a contract or fee arrangement with the Secretary) determines that the provision of mental health services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the limits of Department facilities, be furnished such services on an outpatient basis under the conditions specified in section [1712(a)(5)(B)] *1703(a)(2)(B)* of this title. For the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Department as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 1711(b) of this title).

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CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER ENROLLMENT-BASED SYSTEM

SUBCHAPTER I—GENERAL

§ 1801. Definitions

For purposes of this chapter:

(1) The term "health plan" means an entity that has been certified under the Health Security Act as a health plan.

(2) The term "VA health plan" means a health plan that is operated by the Secretary under section 7341 of this title.

(3) The term "VA enrollee" means an individual enrolled under the Health Security Act and subchapter II of this chapter in a VA health plan.

(4) The term "comprehensive benefit package" means the package of benefits required to be provided by a health plan under the Health Security Act.

SUBCHAPTER II—ENROLLMENT

§ 1811. Enrollment: veterans

Each veteran who is an eligible individual within the meaning of section 1001 of the Health Security Act (including a veteran who is a medicare-eligible individual as defined in section 1902 of that Act) may enroll with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the Department shall enroll with a VA health plan.

§ 1812. Enrollment: CHAMPVA eligibles

(a) ELIGIBILITY.—An individual described in subsection (b) who is eligible to enroll in a health plan pursuant to section 1001 of the Health Security Act may enroll under that Act with a VA health plan.

(b) APPLICABILITY.—This section applies to the following individuals who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS):

(1) The surviving spouse or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

(2) The surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct.

(c) DEFINITION OF CHILD.—For purposes of this section, the term "child" has the meaning given that term in section 1011 of the Health Security Act.

§ 1813. Enrollment: family members

(a) ELIGIBILITY.—The Secretary shall authorize a VA health plan to enroll members of the family of an enrollee under section 1811 or 1812 of this title. The enrollee shall have the option of enrolling in the VA health plan as an individual or with family members. If the enrollee chooses to enroll in the VA health plan with family members, all such family members must be so enrolled.

(b) REQUIRED PAYMENTS.—Any family member enrolled in a VA health plan shall (except as provided in section 1831(c)(2)(B) of this title) be subject to payment of premiums, deductibles, copayments, and coinsurance as required under the Health Security Act.

(c) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH OF VETERAN.—An individual who is enrolled with a VA health plan pursuant to subsection (a) as a member of the family of a veteran enrolled under section 1811 of this title shall not lose eligibility to be enrolled with VA health plans by reason of the death of that veteran.

(d) MEMBERS OF FAMILY.—For purposes of this section, the members of the family of an enrollee are those individuals (other than the enrollee) included within the term "family" as defined in section 1011(b) of the Health Security Act.

SUBCHAPTER III—BENEFITS

§ 1821. Benefits for VA enrollees

The Secretary shall ensure that each VA health plan provides to each individual enrolled with it the items and services in the comprehensive benefit package under the Health Security Act.

§ 1822. Chapter 17 benefits

(a) CARE AND SERVICES NOT INCLUDED IN COMPREHENSIVE BENEFIT PACKAGE.—In the case of care and services that may be provided under chapter 17 of this title that are not included in the comprehensive benefit package, the Secretary shall provide to any veteran (whether or not enrolled with a health plan) the care and services authorized under that chapter in accordance with the terms and conditions applicable to that veteran and that care under that chapter.

(b) VETERANS WHO ARE NOT ELIGIBLE TO ENROLL UNDER HEALTH SECURITY ACT.—In the case of a veteran who is not an eligible individual within the meaning of section 1001 of the Health

Security Act, the Secretary shall provide to the veteran the care and services that may be provided under chapter 17 of this title through any facility of the department, whether or not the facility is operating as or within a VA health plan.

(c) PRESERVATION OF SPECIALIZED DVA TREATMENT CAPACITIES.—In carrying out subsection (a), the Secretary shall ensure that the Department maintains the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services for those specialized needs. The Secretary shall ensure that overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this chapter. Nothing in this subsection precludes the Secretary from expanding the number or type of facilities or programs that provide treatment and rehabilitation services for the specialized needs of such veterans, including provision of specialized services on an outpatient basis.

(d) ANNUAL REPORT.—Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the actions the Secretary has taken to carry out subsection (c) during the preceding fiscal year. Each such report shall include a statement of the number of veterans to whom the Department provided specialized services that are covered by the report and the expense of providing those services, and a description of the alternatives available in the private sector for the provision of those services to veterans.

§ 1823. Supplemental benefits packages and policies

A VA health plan may offer supplemental health benefits packages and supplemental cost sharing policies consistent with the requirements of part 2 of subtitle E of title I of the Health Security Act. However, a VA health plan may not offer a supplemental health benefits package to a veteran that provides coverage for services that the Department is required to provide to that veteran under chapter 17 of this title.

§ 1824. Limitation regarding veterans enrolled with health plans outside Department

(a) REIMBURSEMENT REQUIRED.—A veteran who is residing in an area in which the Department operates a health plan and who is enrolled in a health plan that is not operated by the Department may be provided the items and services in the comprehensive benefit package by a VA health plan operating in that area only if (except as provided in subsection (b)) the plan is reimbursed in accordance with the Health Security Act for the cost of the care provided.

(b) EXCEPTION.—The Secretary may not impose on or collect from a veteran described in subsection (a) a cost-share charge of any kind in the case of treatment for a service-connected disability that (as determined by the Secretary) requires a specialized treatment capacity for which the Department has particular expertise.

§ 1825. Abortions through VA health plans: prohibition

(a) PROHIBITION.—Notwithstanding the provisions of the comprehensive benefit package, a VA health plan may not provide abortions (either by the performance of an abortion in a Department facility or by payment for the performance of an abortion outside a Department facility), except in a case in which—

(1) a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death if the fetus were carried to term; or

(2) the pregnancy is the result of a forcible rape or incest.

(b) CONSTRUCTION OF ABORTION EXCLUSION.—Subsection (a) shall not be construed to remove or diminish coverage of any reproductive health service, family planning service, or service for pregnant women otherwise provided for under this title, except abortions.

(c) NO AUTHORITY TO ALTER ABORTION EXCLUSION.—Notwithstanding any provision of the Health Security Act, the National Health Board may not expand the comprehensive benefit package to include any abortion that is excluded under subsection (a).

SUBCHAPTER IV—FINANCIAL MATTERS

§ 1831. Premiums, copayments, etc.

(a) EXEMPTION OF CERTAIN VETERANS.—In the case of a veteran described in subsection (b) who is a VA enrollee, there may not be imposed or collected from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items and services in the comprehensive benefit package that are provided to the veteran by the Secretary within a VA plan provider network. The Secretary shall make such arrangements as necessary with the appropriate health insurance purchasing cooperative or with appropriate Federal, State, or other officials in order to carry out this subsection.

(b) VETERANS EXEMPT FROM CHARGES.—The veterans referred to in subsection (a) are the following:

(1) Any veteran with a service-connected disability.

(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

(4) Any veteran who is a former prisoner of war.

(5) Any veteran of the Mexican border period or World War I.

(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(c) OTHER ENROLLEES.—(1) In the case of a VA enrollee who is not described in subsection (b), the Secretary shall (except as provided in paragraph (2)) charge premiums and shall establish copayments, deductibles, and coinsurance amounts.

(2) The Secretary may not collect from an enrollee a premium in the case of—

(A) an individual who is enrolled in a VA health plan by reason of eligibility under section 1812 of this title; or

(B) an individual who is enrolled in a VA health plan by reason of eligibility under section 1813 of this title and who is described in paragraph (1) of section 1713(a) of this title.

(3) The Secretary may not charge a copayment, deductible, or other coinsurance amount in the case of care for any disease covered under section 1710(e)(1) of this title.

(d) ESTABLISHMENT OF RATES.—The premium rate, and the rates for deductibles and copayments, for each VA health plan shall be established by that health plan based on rules applicable to all health plans operating in the geographic area in which it is operating.

(e) SELF-EMPLOYED SERVICE-CONNECTED VETERANS.—In the case of a veteran with a service-connected disability who is enrolled in a VA health plan and who has net earnings from self-employment, the Secretary shall, under regulations prescribed by the Secretary, provide for the waiver of any premium payment (or alliance credit repayment) owed by the veteran under section 6126 or 6111 of the Health Security Act by virtue of the veteran's net earnings from self-employment.

(f) DUTIES OF EMPLOYERS.—The obligations (including obligations with respect to payment of premiums) under the Health Security Act of an employer with respect to employees who are enrolled in a VA health plan, and with respect to such a plan, shall be the same as those that apply with respect to other employees and other health plans.

§ 1832. Medicare coverage and reimbursement

(a) PAYMENTS FROM HHS.—In the case of care provided by the Department to an individual who is a Medicare-eligible individual other than a veteran described in section 1831(b) of this title, the Secretary of Health and Human Services shall reimburse the Department health-care facility or VA health plan that (under subsection (b)) provides that care as a Medicare provider or Medicare HMO in the same amounts and in the same manner as that Secretary reimburses other Medicare providers or Medicare HMOs, respectively. The Secretary of Health and Human Services shall include with each such reimbursement a Medicare explanation of benefits.

(b) MEDICARE STATUS.—(1) For purposes of the Medicare program—

(A) a Department health care facility providing care to a Medicare-eligible individual for which there is a certification in effect under paragraph (2) shall be deemed to be a Medicare provider; and

(B) a VA health plan providing care to a Medicare-eligible individual for which there is a certification in effect under paragraph (2) shall be deemed to be a Medicare HMO.

(2) The Secretary shall certify to the Secretary of Health and Human Services each year—

(A) a list of all Department health care facilities that, with respect to Medicare requirements that are applicable to a public facility, either fully meet or exceed Medicare requirements, or fully comply with requirements of the Secretary that are intended to achieve the same or similar purposes as Medicare requirements and which are no less stringent than such Medicare requirements; and

(B) a list of all VA health plans that, with respect to Medicare HMO requirements that are applicable to a health plan of a public entity, either fully meet or exceed Medicare HMO requirements, or fully comply with requirements of the Secretary that are intended to achieve the same or similar purposes as Medicare HMO requirements and which are no less stringent than such Medicare requirements.

(c) DEDUCTIBLES AND COPAYMENTS.—When the Secretary provides care to an enrollee with a VA health plan for which the Secretary receives reimbursement under this section, the Secretary shall require the enrollee to pay to the Department any applicable deductible or copayment that is not covered by the Medicare program.

(d) DEFINITIONS.—For purposes of this section:

(1) The term "Medicare program" means the health insurance program under title XVIII of the Social Security Act.

(2) The term "Medicare-eligible individual" means an individual who is entitled to benefits under part A of the Medicare program.

(3) The term "Medicare HMO" means an eligible organization under section 1876 of the Social Security Act.

(4) The term "Medicare provider" means an individual or entity furnishing items or services for which payments may be made under the Medicare program.

§ 1833. Recovery of cost of certain care and services

(a) RECOVERY FROM THIRD PARTIES.—In the case of an individual provided care or services through a VA health plan who has coverage under a supplemental health insurance policy pursuant to part 2 of subtitle E of title I of the Health Security Act or under any other provision of law, or who has coverage under a Medicare supplemental health insurance plan (as defined in the Health Security Act) or under any other provision of law, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

(b) PROCEDURES.—The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

§ 1834. Health Plan Fund

(a) ESTABLISHMENT OF FUND.—There is hereby established in the Treasury a revolving fund to be known as the "Department of Veterans Affairs Health Plan Fund".

(b) CREDITING OF AMOUNTS TO FUND.—There shall be credited to the revolving fund any amount received by the Department by reason of the furnishing of health care by a VA health plan and any amount received by the Department by reason of the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles), any amount received as a third-party reimbursement, and any amount received as a reimbursement from another health plan for care furnished to one of its enrollees.

(c) CREDITING TO TREASURY.—Any amounts deposited to the revolving fund that are attributable to amounts received by the Department as a premium by reason of the enrollment with a VA health plan of a veteran described in section 1831(b) of this title shall be covered into the General Fund of the Treasury.

(d) AVAILABILITY OF FUNDS.—Amounts in the revolving fund are hereby made available for all expenses, both direct and indirect, related to the delivery by a VA health plan of the items and services in the comprehensive benefit package and any supplemental benefits package or policy offered by that health plan.

§ 1835. Guaranteed funding of Government costs

(a) REQUIRED DEPOSITS FROM TREASURY.—The Secretary of the Treasury shall deposit into the Department of Veterans Affairs Health Plan Fund on the first day of each fiscal year quarter, from amounts not otherwise appropriated, the amount certified to the Secretary under subsection (b) with respect to the fiscal year quarter beginning on that date. The first such deposit shall be made with respect to the first fiscal year quarter during which the Secretary operates a VA health plan under the Health Security Act.

(b) CERTIFICATION OF AMOUNT.—Not later than 30 days before the beginning of each fiscal year quarter, the Secretary of Veterans Affairs shall certify to the Secretary of the Treasury the amount determined for that quarter under subsection (c).

(c) DETERMINATION OF AMOUNT.—(1) The amount to be certified to the Secretary of the Treasury under subsection (b) for any fiscal year quarter is the product of—

(A) the projected number of VA enrollees described in section 1831(b) of this title as of the beginning of that fiscal year quarter, and

(B) the capitated enrollment amount for that fiscal year determined under subsection (d).

(2) The Secretary shall adjust future certifications under this subsection to take account of—

(A) differences between the actual number of veterans described in section 1831(b) of this title enrolled for a fiscal year quarter and the projected number used in the certification for that quarter pursuant to paragraph (1); and

(B) any information that the Secretary finds would produce a more accurate capitated enrollment amount by enabling the Secretary to estimate more accurately the costs that the Depart-

ment will incur during the period covered by any such certification in providing those services that are specified to be included in the comprehensive benefit package.

(d) CAPITATED ENROLLMENT AMOUNT.—(1) The Secretary shall determine the capitated enrollment amount for purposes of subsection (c). The initial capitated enrollment amount shall be determined as the amount equal to—

(A) the annual full cost (as defined in OMB Circular A–25, issued on July 8, 1993) that has been incurred by the Department in providing those services that are specified to be included in the comprehensive benefit package, based upon the most recent cost data available as of the time of the determination, adjusted for inflation to the date of the determination based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, divided by

(B) the total number of veterans described in section 1831(b) of this title who received those services.

(2) The Secretary shall include in the total annual cost for purposes of paragraph (1)(A) the amount appropriated for fiscal year 1994 for the medical and prosthetic research functions of the Veterans Health Administration.

(3) The Secretary shall develop the methodology for determining the initial capitated enrollment amount under paragraph (1) in consultation with the Comptroller General of the United States. If the Comptroller General disagrees with the methodology proposed to be used by the Secretary, the Comptroller General shall promptly notify the Committees on Veterans' Affairs of the Senate and House of Representatives. The determination of that amount shall be made not later than June 1, 1995.

(4) The initial capitated enrollment amount, as adjusted annually for inflation based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, shall apply for the first five fiscal years during which the Secretary operates a VA health plan.

(5)(A) Not later than the end of the third fiscal year during which the Secretary operates a VA health plan, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on what actions, if any, would be necessary in order for the Department to change the annual capitated enrollment amount by the end of the fifth such year from the initial amount determined under paragraph (1) to an amount determined using the method described in subparagraph (B), or to amounts determined using some other methodology, without a reduction in quality of care.

(B) The method for determining the annual capitated enrollment amount for purposes of the study under this paragraph is to determine the average premium that would be payable under the Health Security Act for individuals enrolled in health plans other than VA health plans which have enrollment populations with disproportionate numbers of persons with similar demographic and patient-risk characteristics to the population of VA enrollees.

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

SUBCHAPTER I—ORGANIZATION

Sec.

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[SUBCHAPTER IV—RESEARCH CORPORATIONS]

SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

7341. Organization of health care facilities as health plans.
7342. Operation of health care facilities within States operating as single payer areas.
7343. Health care resource agreements.
7344. Administrative and personnel flexibility.
7345. Veterans Health Care Transition Fund.
7346. Funding provisions: grants and other sources of assistance.

SUBCHAPTER V—RESEARCH CORPORATIONS

7361. Authority to establish; status.

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SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

§ 7341. Organization of health care facilities as health plans

(a) Except as provided in section 7342 of this title, the Secretary shall organize health plans and operate Department facilities as or within health plans under the Health Security Act. The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as or within health plans under that Act. In prescribing those standards, the Secretary shall assure that they conform, to the maximum extent practicable, to the requirements for health plans generally set forth in part 1 of subtitle E of title I of the Health Security Act.

(b) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single health plan encompassing all Department facilities within that area or region or may be organized to operate as several health plans.

(c) Within a geographic area or region other than a State (or portion of a State) that under the Health Security Act is a single payer area, any health insurance purchasing cooperative, health alliance, or similar entity that offer health insurance plans shall offer as an option to eligible individuals any VA health plan that is operating in that area or region.

(d) Any health insurance program that is provided for Federal employees shall include VA health plans as enrollment options for eligible individuals. Premiums shall be paid to a VA health plan under any such insurance program based upon enrollment with that plan in the same manner as to any other health plan.

(e)(1) In establishing and operating health plans, the Secretary, in consultation with the Comptroller General, shall take appropriate steps to ensure the financial solvency and stability of each VA health plan and of contractors and subcontractors providing services pursuant to section 7343 of this title.

(2) In carrying out paragraph (1), the Secretary may purchase from commercial sources insurance to insure the Department against the financial risks involved in the operation of any VA health plan.

(3) Notwithstanding any other provision of law, there shall be no requirements applicable to a VA health plan with respect to the maintenance of a reserve fund, requirements to reinsure, or payments into any other financial integrity fund other than as established pursuant to paragraph (1).

(f) In carrying out responsibilities under the Health Security Act, a State (or a State-established entity)—

(1) may not impose any standard or requirement on a VA health plan that is inconsistent with this section or any regulation prescribed under this section or other Federal laws regarding the operation of this section; and

(2) may not deny certification of a VA health plan under the Health Security Act on the basis of a conflict between a rule of a State (or State-established entity) and this section or regulations prescribed under this section or other Federal laws regarding the operation of this section.

§ 7342. Operation of health care facilities within States operating as single payer areas

(a) In a State (or portion of a State) that under the Health Security Act is operating as a single payer system, Department health care facilities in that State (or portion of a State) shall serve as providers to individuals residing in that State (or portion of a State) who would be eligible to enroll under chapter 18 of this title with a VA health plan if they were residing in an area where there were health plans operating under the Health Security Act. Such facilities may provide those individuals any covered service in the comprehensive benefit package.

(b) A Department facility providing care to residents of a single payer area pursuant to subsection (a) shall be reimbursed for that care on the same basis as any other provider furnishing the same services in that area.

(c) A veteran described in section 1831(b) of this title shall be exempt from any otherwise applicable charges for such care. Any other individual provided care pursuant to subsection (a) shall be subject to all applicable requirements respecting copayments, deductibles, and coinsurance. Notwithstanding the preceding sentence, section 1831(c)(3) of this title shall apply to any such charge.

§ 7343. Health care resource agreements

(a)(1) In accordance with policies established under subsection (b), an official specified in paragraph (2) may, without regard to any law or regulation specified in paragraph (3), enter into agreements with health care plans, with insurers, and with health care providers, and with any other entity or individual, to furnish or obtain any health-care resource.

(2) An official specified in this paragraph is any of the following:

(A) The head of a VA health plan.

(B) The director of a Department health care facility that is operating as or within a VA health plan.

(C) The director of a Department health care facility that is operating in a State (or portion of a State) that under the Health Security Act is a single payer area.

(3) A law or regulation specified in this paragraph is any of the following:

(A) Section 1703 of this title.

(B) Any other law or regulation pertaining to—

(i) competitive procedures;

(ii) acquisition procedures or policies (other than contract dispute settlement procedures); or

(iii) bid protests.

(4) For purposes of this subsection, the term "health-care resource" has the meaning given that term in section 8152 of this title.

(b) Policies established by the Secretary under subsection (a) shall include appropriate provisions to ensure that procurements under that subsection are carried out in a manner consistent with (1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse, and (2) the goal of a streamlined process for the acquisition of health-care resources.

(c) Any proceeds to the Government received from an agreement under subsection (a) shall be credited to the Department of Veterans Affairs Health Plan Fund established under section 1834 of this title and to funds that have been allotted to the facility that furnished the resource involved.

§ 7344. Administrative and personnel flexibility

(a) In order to carry out this subchapter, the Secretary may—

(1) subject to section 1822(c) of this title, carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

(2) when the Secretary finds it is cost-effective or necessary in order to provide health care services in a timely manner—

(A) enter into contracts for procurement of any commercially available item at a cost of under $100,000 without regard to any provision of law or regulation (i) requiring competitive procedures; (ii) mandating or giving priority to any source of supply; or (iii) pertaining to protests; and

(B) enter into contracts without regard to section 8110(c) of this title for the performance of services previously performed by employees of the Department.

(b)(1) The Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or with health plans under the Health Security Act, or for personnel at facilities operating in a State (or portion of a State) that under the Health Security Act is a single payer area, whenever the Secretary considers such action necessary in order to carry out the terms of that Act, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

(2) In establishing alternative personnel systems or procedures under this subsection, the Secretary shall include the following:

(A) A system that ensures that applicants for employment and employees are appointed, promoted, and assigned on the basis of merit and fitness.

(B) An equal employment opportunity program.

(C) Compensation systems which will be used to set rates of pay that are competitive with rates of pay paid by health-care providers other than the Department and that take into consideration the difficulty, responsibility, and qualification requirements of the work performed.

(D) A formal performance appraisal system.

(E) A system to address unacceptable conduct and performance by employees, including a general statement of violations, sanctions, and procedures which shall be made known to all employees, and a dispute resolution procedure.

(F) A formal policy regarding the accrual and use of sick leave and annual leave.

(c) Subject to any provisions of the Health Security Act relating to, or placing limitations on, the marketing of health plans and information that must be provided by health plans, the Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans.

§ 7345. Veterans Health Care Transition Fund

(a) For each of fiscal years 1995, 1996, and 1997, the Secretary of the Treasury shall credit to a special fund (in this section referred to as the "Fund") of the Treasury an amount equal to—

(1) $1,250,000,000 for fiscal year 1995;

(2) $850,000,000 for fiscal year 1996; and

(3) $1,950,000,000 for fiscal year 1997.

(b) Amounts in the Fund shall be available to the Secretary only for the VA health plans authorized under this chapter. Such amounts are available without fiscal year limitation for costs of commencing operation of VA health plans, including consulting services, equipment, marketing, and other costs, minor construction, and (subject to section 8104 of this title) major construction.

(c) The Secretary shall submit to Congress, no later than March 1, 1997, a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, national health care reform under the Health Security Act during fiscal years 1995 and 1996. The report shall include a discussion of—

(1) the adequacy of amounts in the Fund for the operation of VA health plans;

(2) the quality of care provided by such plans;

(3) the ability of such plans to attract patients; and

(4) the need (if any) for additional funds for the Fund in fiscal years after fiscal year 1997.

§ 7346. Funding provisions: grants and other sources of assistance

The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to fa-

cilities of the Department or to health plans operated by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.

SUBCHAPTER [IV] *V*—RESEARCH CORPORATIONS

§ 7361. Authority to establish; status

(a) The Secretary may authorize the establishment at any Department medical center of a nonprofit corporation to provide a flexible funding mechanism for the conduct of approved research at the medical center. Except as otherwise required in this subchapter or under regulations prescribed by the Secretary, any such corporation, and its directors and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives which apply generally to private nonprofit corporations.

(b) If by the end of the four-year period beginning on the date of the establishment of a corporation under this subchapter the corporation is not recognized as an entity the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, the Secretary shall dissolve the corporation.

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